Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2012ª Charles Kestler, Sr. Vernon 9:20 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shangrila Assisted Living Ellicott City Howard Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) Maryland 1 🕱 M 2 🗆 F Days Months Hours 08-07-1919 213-05-3067 **Director** 92 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Howard 1 Yes XX No. Ellicott City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4213 Rose Petal Court 21043 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? ▼ Yes 2 □ No 1944Yes, Give Black, White, etc. 1 Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: 3 Nidowed 4 Divorced Completed 1946 White 12 should be filed within 72 hours a aith and Mental Hygiene. 27 is marked other than "natural r traumatic event, the Medical Ex Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Asselbly Supervisor Maryland Cup Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Lee Kestler, Sr. Margaret M. Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 4213 Rose Petal Court, Ellicott City, Maryland Carol L. Heber - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pak: 01-12-2012 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland e of Funcial Service License 21. Signat 22. Name and Address of Facility Gary L. kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of): ≟xaminer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burlal-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atal or Attending response after death.

In all Director. After this certificate has been signer than the funeral director, page 2 should be Completed 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Assist. Living 잍 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of ny knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Tanos 7017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 6334 Cedar Lane, #103, Columbia, MD 21044 Andrew Lazris.

H DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

JAN 1 9 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
#27 Per PHY G923 1/26/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 7:12 PM January Medical 2012 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore of Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Director** 1 M 2 M 10-22-1936 28a-f show 10a. State 10b. Count permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 275 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10c. City, Town or Location 10d. Inside City kimits Director 1 ≝Yes 2 ☐ No IMORP 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21202 12. Was Decedent Ever Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 þ Baltimore, Maryland 21215-0036 ☐ Married If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည 19a. Informant's Name/Relationship (Type, Prig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🌙///🎵 Patient 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 Burial 2 Cremation 3 Removal from State 24-2012 4 ☐ Donation 5 ☐ Other (Specify) Laurel, 21. Signature of Funeral Servi, e Licensee O. Greene Funeral Services 22. Name and Address of Facility 9 Road 15town, mD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Rhysician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): **E**xaminer Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute Due to (or as a consequence of) and I-transit Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Metastatic colon cance Due to (or as a consequence of): attending physician a d for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day been signed by the should be detached 9 Unknown 9 Unknown P.0. by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, mellitus Completed Type 2 Diabetes 1 Yes 2 🗹 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an has autopsy page perform this certificate 2 🗹 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1**XX**Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (Bli MD RES - 000 January 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haspital Baltimoro of Elliott Sinai 31. Date filed State Registrar's Signature 1 9 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 12 01003 1 - State AMEND PI LINE B, 25, 27, 28A-F, REPLIFICATE OF DEATH 12 TRT Reg. No. Decedent's Name (First, Middle, Last) Russell Allen Laisure 2. Date of Death 3. Time of Death Day Physician/ 1744 M 2012 - CATIVAR Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Homere Cit he wohns Hopking Hospital Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, Year) Hours Country) Months Days 220-12-5547 1 XXM 2 🗆 F January 31,1926 MD **Director** 85 Usual Residence of Dece 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County must be notified at Director Baltimore MD N/A XX Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 by Funeral 23a U.S.A. 21211 1103 Woodheights Avenue 12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Hygiene. other than "natural", or iter ent, the Medical Examiner r 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21/2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Atlantic Caterer traumatic event, the marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٥ Ella McCaine Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1103 Woodheights Avenue Baltimore, MD 21211 Deborah Bowers (daughter) injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Page 1 s Department of Important: If it any injury or o 1 XXeurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest , Maryland Maryland Veterans' Cemetery 1/20/12 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** RIGHT HIP FRACTURE Sequentially list conditions, Examiner Due to or as a consequence of if any loading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APP and Due to (or as a consequence of) attending physician Physician/Medical 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy jo in the past 12 months? Pregnant at time of death ed by the a Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 2 No 3 Probably 4 Unknown 1 Yes Records, Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? nas 1 Yes 2 No this certificate Yes 2 □ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 Other: ပ္ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director, After t Certificate: work? 1 ☐ Yes 2 XNo 1 Natural 2 Accident UNK SUBJECT FELL 1/06/2012 Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 103 WOOD HEIGHTS filled in by 4 Homicide determined AVE, BALTIMORE, MD HOME Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number RESUGO 29d. Date signed (Month, Day, Year) 29b. Signature a 15,2012pleted cause of death (Item 23a) (Type, Print) ddress of person who co ne and 600 M. Wolfe St. Baltmore, mo 21287 Hitspatrick ames 31. Date filed (Month, Day, Year). Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01004 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Janta 1011 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 NC 7. Age (In vrs. last birthday **Funeral** 1 🗆 M 2 💢 F Days Hours Min 69 218-40-2582 NC Feb Ï942 Director Usual Residence of Decedent 28a-f shov Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Carroll Sykesville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1309 Woodridge Lane 21784 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Earl Swanner Frances Edith Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Franklin Lord (spouse) 1309 Woodridge Ln., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Lake View Memorial 1-21-12 Sykesville, MD 4 Donation 5 Other (Specify) permit. 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ clerod disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Other (specify) 4 Pregnant a Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? HOSAGE Hospital Other: 4 Nursing Home 5 Residence 6 Other (S 2 No 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific Center ento. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 3.20 M slas 0 2012 EAN Medical 4c. County of Death 4b. City, Town or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltomex Cont mmuri 7. Age (In yrs. last birthday) 68 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Min California 540-42-6871 1 XM 2 □ F 1943 Director 0ct Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA by Funeral 2338 Fleet St. 12. Was Decedent Ever in U.S.
Asyned Forces?
1 Yes 2 No
If Yes, Give 196 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1965 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🕅 No Specify: 1968 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) carpentry 12 carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leah Lucille Brigham Clarence Woodrow Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38168 Beachwood Ct #5; Frankford, Delaware 19945 Charisse Lee - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Signature of Funeral Service 122 ector 655 W. Baltimore St; Baltimore, MD 21201 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest k, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician disease or con itie resulting in death) a Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 Tes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Effertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, JAN 1

Ravis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2012

350

Lock

2735

Boulevar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Physician/ 2012 4:10 Edgar Рм Τ. Linder Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Davs Hours Min 212-28-4551 Director 1 😿 M 2 🗆 F 93 1918 Sept 8. Maryland ral", or items 23a or 28a-f show Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 X No MD. Baltimore Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8820 Walther Blvd. 21234 **USA** death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify If Yes. Give Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Auto Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Edgar Τ. Linder Elizabeth Kreiner 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trains once E. Thomas Linder/ Son 3606 My_Lady's View Monkton, MD. 21111 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 1-19-12 Most Holy Redeemer Baltimore, MD. 4 ☐ Donation ,5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Home, Signature of Full ral Su vice Liq 1050 York Rd. Towson, MD 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical requires that the death certificate be P.O. Box 68760 the attending IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Year Pregnant at time of death 2 🗌 No 9 Unknown signed by biting to death but not resulting in the underlying cause given in Part I. Other significant conditions con 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably Division of Vital Records, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an • Hospital or Attending Physician: The law in 24 hours after death. • Funeral Director: After this certificate has b autopsy performe death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Local Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certify: Nursa Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature nd title of certif 29c. License number 29d. Date signed (Month, Day, Year) 18211000 40 SIL an, granding, 2014 * ha 0 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Kenneth Masters lanue AM 2012 45 Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Baltimae Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, Min Hours 219-42-2549 1**X** M 2 □ F Director 68 Aug. 16,1943 Washington DC Usual Residence of Decedent works 10h Count 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 Tes 2 No Catonsville Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1809 Edmondson Avenue 21228 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Types 2 No 1966If yes, Give Black White, etc. þ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify 1969 White Completed Year or Dates er than "natura", the Medical E Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life, DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) n and Mental Hygien 7 is marked other the Legal Attorney Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Hubert Masters Kathleen Malonev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Patricia Masters / Wife 1809 Edmondson Ave., Catonsville, Maryland 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/18/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ unel disease or condition resulting in death)) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) trar that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical P.O. Box 68760 attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav Year the 9 Unknown Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law cate has l perform death? Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA HOGRACE 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident work? 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A Investigation М Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F RES0001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAGENDA State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day 931 Physician/ MCS rankle 201 Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (if not institution, give street and number **Examiner** Ltimule Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** 215-42-6417 **Director** 1 X M 2 □ F 68 Yrs. Feb 26, 1943 Illinois Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Churchville Harford Maryland 10g. Citizen of What Country? 0 10e. Street and Number must be n Funeral USA 21028 5 Bramble Lane "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 X Yes 2 □ No 1961 Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 1965 Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Brickmason Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Violet Green Francis Wavne McDowell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 Bramble Lane Churchville, Maryland 21028 Julia Katherine McDowell, Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 01/18/12 4 Donation 5 Other (Specify) Metro Crematory Inc. ²² Name and Address of Facility Cremation Society Of Maryland, 299 Frederick Road Baltimore, 21. Signature of Funeral Service License Thomas Gregor Inc. Marvland 21228 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Coli teronua disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2X No within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA ျ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural work?
1 Yes 2 No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Sign D1172012 leted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Day Mott Month Year Demarcus Leroy 3:54PM 2012 Tan 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Agnes Baltimore hospita If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 105 25 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 □ F Days Min. Hours Country) **Director** 21 216-29-5809 "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NA Baltimore MD 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 3901 Bevera Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ⚠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10th grade Disabled Disabled Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked others injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tonya Miller Michael Mott 19a. Informant's Name/Relationship (Type, Pring) rand Geraldine Miller-Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3901 Bevera Road, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Sacred Heart of Jesusl/18/12Dundalk, Md Signature of Juneral Service Lig archand Hes West a 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. 14mphoma months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate odde. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year been signed by the strough be detached q | Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 performed? death? 1 Yes 2 1 NO Yes 2 1 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending neral Director; A 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D25482 Jan 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bishow Ch. Shrestha 21229 900 31. Date filed (Month, Day, Year) State Signature Registrar

JOMOVCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) marshall Physician/ Janyar ZD17 ever Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** n/a Raltymore 9. Birthplace (State or Foreign Country) MD Date of Birth If Under **Funeral** Months / (Month, Day, Year) 09/25/1964 154-64-7305 1 XM 2 □ F **Director** 47 Usual Residence of Decedent 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director Baltimore 1X Yes 2 ☐ No n/a MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 Funeral 602 Winans Way Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 14. Race - American Indian, 11. Marital Status unk Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 😾 No Specify. Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Winthrope House Security Guard and Mental Hygie is marked other injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosemary Wheatley Henry Augustus Kellogg Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is 1 any injury or 201 602 Winans Way Baltimore, MD 21229 Daona Barnes- Fiance 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethel Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Cambridge, MD 1.21.2012 Donation 5 Other (Specify) 22. Name and Address of Facility John L. Williams Funeral Directors, 4517 Park Heights Ave Baltimore, MD sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate 23a, Part 1. Enter the disease, or complications that nterval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-transi and Due to (or as a consequence of): the attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Was a.. autopsy performed? After this certificate has 1 Yes 2 No 26. Place of Death (Check only one) To the Hospital or Attending Physician: funeral director. 25. Was case referred to medica To Be ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death Certificate: injury 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A filled in by the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide Could not be 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and titl completed cause of death (Item 23a) (Type, Print) 000 North Waite St. Baltimoramo Z1287 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 9:10 AM Physician/ Moses 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE DEADRIGHT AVENU in dalk If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign ecurity Number 7. Age (In vrs. last birthday) **Funeral** 925 Months Hours Min (Month, Day, Year, **Director** 1 X M 2 🗆 F -16-1953 5 B A Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State the Medical Examiner must be notified at Director BALTIMORE 1 Yes 2 No NDAL 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Numbe Funeral 23a USA od bright Avenue 21223 items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) RUCKING Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) ည Moses DOFFL GENEVIEVE 19a. Informant's Name/Relationship (Type, Print) (wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barri mo Avenue MARION リタチュ 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 Donation 5 Other (Specify) BALTIMORE -2012 of Funeral Service Lice 2134 Willow Springs Bartimb 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 9 0 ance disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consecuence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been examed to the control of th Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant a Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes been signature should be Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Oo o 24a. Was an page 2 autopsy Yes 2 No completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie Date signed (Month, Day, Year) J ath (Item 23a) (Type Print) 30. Name and address of person who completed cause of de selun 38 32. Registrar's Signatur filed (Month, Day, Year)
JAN 1 9 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Paul Vincent Myron, Jr. Physician/ 6:20 A January 16, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery Bethesda 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 🛛 M 2 🗆 F July 12, 1938 73 Wasmington, D.C. 577-52-6050 Director Yrs. Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland at Director or 28a-f s 1 Yes 2 No N. Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe ms 23a o Funeral United States 5550 Tuckerman Lane, 20852 #233 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 0, þ 1 🗷 Never Married 2 🗌 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. Specify. "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me ginee. Elementary/Seconday (0-12) College (1-4 or 5+) Mental Health Psychiatrist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Catherine B. Sullivan Paul Vincent Myron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8017 Aberdeen Road, Bethesda, Maryland 20814 Regina G. Bjornlund/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 20, Gate of Heaven Maus Sieum 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment 2012 Silver Spring, Maryland 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Rockville, inc. 300 West Montgomery Avenue Signature of Funeral Service Liourisee do M01498 The ster 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Duodenal Perforation Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Upper Gastrointestinal Bleeding Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical $\mathbb{M}_{\mathsf{N}}\mathsf{TDM}_{\mathsf{I}}$ $\mathsf{PAW}_{\mathsf{I}}$ Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 🖾 No မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Pes 2 No Natural injury 5 Pending 2 Accident Investigation after death Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined I filled in I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hc

To the Function

completed to Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certile 66269 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 8600 Old Georgetown Road, Bethesda, Maryland 20814 Babak Salehi Pirouz, 31. Date filed (Month, Day, 32. Registrar's Sanature State **JAN 1** 9 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Xinmin Physician/ Ma January 16, 2012 7:27 P M Medical a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours 79 **Director** 1 X M 2 🗆 F Jan. 19, 1932 China Usual Residence of Decede 28a-f shov 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a, State 10c. City. Town or Location Director items 23a or 28a-f s ner must be notified DANLARY 1412012 1 X Yes 2 No Liaoning China Fushun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5-301 Building 13 Faku Street China 113001 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Asian Completed 3 Widowed 4 Divorced 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Coal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Baokun Li Canzhen Ma MA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14528 Snapdragon Circle, Gaithersburg, Maryland 20878 Liqing Ma/Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to MINGKING 20b. Place of Disposition (Name of Montgomery crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date January 19, 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012<u>Crematoriúm,</u> Inc. Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death atherosclerotic cardiovascular discage Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of,... Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of) nding physician by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Dav 5 Other (specify) Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Y No ဥ 1 Inpatient 2 MER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury 1 Natural work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a of certifier ATTENDING D00 63941 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NILANTHA LENGRA. 9901 MEDICM CENTER DRIVE ROCKVIUE MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 1 9 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Edward Miller 1700 01 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** 220-18-5347 84 Yrs. **Director** 1 🕅 M 2 🗆 F Jan 19,1927 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director notified Anne Arundel Linthicum 1 Tes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 533 Hawthorne Road 21090 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter edical Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) er than Elementary/Secondary (0-12) College (1-4 or 5+) Police Officer Law Enforcement event, the Be 17. Father's Name (First, Middle, Last) ent of Health and Mental H it: If item 27 is marked ot y or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Miller Anna Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna J. Miller - Wife 533 Hawthorne Road, Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or Meadowridge Memorial Park 1/20/12 Elkridge, Maryland 4 ☐ Dopation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that conshock, or wart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) neumonia Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physician and s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day been signed by the a should be detached t Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Failure 1 Yes 2 No 3 Probably 4 Unknown Metastatic Renal Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy perform 1 Yes Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral Completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOSPITAL DR. GLEN BURNIE, MOZIOGO 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Willian

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Year Jarion een 9:52 PM Medical JANUARY 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE SINAL HOSPITAL OF CITY Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min 2229 Director 1 🗆 M 2 🗹 F amaica show injury or other traumatic event, the Medical Examiner must be notified at City, Town or Location 10d. Inside City Limits Completed by Funeral Director items 23a or 28a-f 1 Yes 2 No STOWN 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8822 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 0 Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) ၉ Brown ite Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Rg 8823 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Vim one a 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Luchn C Greene Funeral Services Randa 115town. 23a. Part 1. Enterfule disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition METABOLIC ACIDUSIS DAY Medical resulting in death) Due to (or as a consequence of): Examiner BRONCHOPLEURAL MONTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that the death certificate be executed Cause (Disease or injury that initiated events HYPOTENSION MONTH attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical $\#\mathcal{A}\mathcal{C}$ Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Day Month Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARDS 1 Yes 2-No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? MULTIPLE MYELOMA 24a Was an autopsy performed PNEUMONIA 1 Yes 2 No Yes 24 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Vars MBBS JANUARY 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MBBS, MALHOTPA SINAI HOSPITAL OF 32. Registrar's Signature State Registrar

せられにろ

スターエノののこ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 19:46 M 15 2012 January PRINGLE DONALD ELROY Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner HARFORD CO BELAIR UPPER CHESAPEAKE MEDICAL CENTER 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Director 213-36-8576 1 X M 2 □ F MARYLAND 74 APRIL 3 1937 Usual Residence of Decedent 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene, important, or items 23a or 28a-f sho important; If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🗓 No HARFORD CO BELAIR MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21014 410 FRANKLIN ST. APT 3 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 XXMarried Completed by 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify Specify: BLACK 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ALSPHALT CONSTRUCTION 10th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည MARY PRINGLE WILLIAM PRINGLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 410 FRANKLIN ST. APT 3, BELAIR, MARYLAND 21014 Darlene Pringle/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 🎇 Burial 2 □ Cremation 3 □ Removal from State MONKTON, MARYLAND 01-21-12 4 Donation 5 Other (Specify) MT. JOY A.M.E. CEM. WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S PHILA. BLVD., ABERDEEN, MD. 21001 21. Signature of the e 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) UNKNOWN Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE: Live Birth 2 Fetal death 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Month signed by the a 1 Yes 2 L 9 Unknown 9 Unknown 18004/4/13 Pringle 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P. à 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 W 25. Was case referred to medical examiner? 26. Place of Death (Check only one) or Attending Physician: the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Hospital: ၉ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DOG 53568 500 Upper Chesapeake 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1000 thompson 32. Registrar's Signature iled (Month, Day, Year) State a 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ January 1:50 P^M Vivian Astroth Phillips Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (if not institution, give street and number) **Examiner** Baltimore Catonsville Renaissance Gardens 8. Date of Birth
Dec 23, Year 916 9. Birthplace (State or Foreign Country) Missouri 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Hours 1 - M 2 X F 95 **Director** 488-09-6203 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 No <u>Catonsville</u> Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral 21228 USA 709 Maiden Choice Lane RG S120 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 Ves 2 No 1943
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3X Widowed 4 ☐ Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Det artment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meaons. College (1-4 or 5+) Elementary/Seconday (0-12) Public Schools Guidance Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Georgia Younger Miller August Elmer Astroth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1933 Blue Mount Road Monkton, Maryland 21111 Carol P. Downing, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ☐ Burial 2 X Cremation 3 ☐ Removal from State 01/19/12 Baltimore, Maryland Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Thomas Gregor ^{22. Name and Address of Facility} Cremation Society Of Maryland, 299 Frederick Road Baltimore, N Maryland 21228 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cashe on each line. Approximate Interval Betwee Onset and Death Immediate Cause (Final disease or condition End Physician/ Stag Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or linjury that initiated events that the death certificate be executed and-trans Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) Day in the past 12 months? Month Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by e Hospital or Attending Physician: The law requires to thours after death.

24 hours after death.

Funeral Director: After this certificate has been sign eled filled in by the funeral director, page 2 should be leted filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 2 No ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: 5 Pending 1 Matural 1 Yes 2 No Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Under the Course of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar
DHMH 17 Rev 7/2009

ORIGINAL

Burk hardt

32.

Registrar's Signature

31. Date filed (Month, Day, Year)

CLAP 709 Maiden Choice Lane Baltimore, MD 21228

12-00359 Camilla Parham Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_	. , ,	
	State of Maryland /	Department of Health and Mental Hygiene

2	0		2	0		0	3
States	\sim	- 6	Distance .		- 0	~	-

		I-For State Registrar	Cei	rtificate o	f Death				g. No.	
Physicia Medical Examir	ın/	Decedent's Name (First, Middle,Last) Camilla	Jordan		Parha	a m		Date of Deat Month January 12	Day Year	3. Time of Death 1530 hrs
	۲	4a. Facility Name (if not institution, give st Johns Hopkins Bayview Med			4b. City, Town Baltimore		n of Death		4c. County of [Death
	4	5. Social Security Number 6. Sex	7. Age (In yrs. I	ast hirthday)	If Under 1		der 24Hrs.	8. Date of Bir	th(MM/DD/YYYY) S	9. Birthplace (State or
Funeral Director	ļ		₂ [X] _F 87	Yrs	Months [Days Hou		07	24 F	oreign MD
	ŀ	Usual Residence of Decedent	2.35		<u> </u>					
any	ı	10a. State 10b. County		Town or Local						10d. Inside City Limits
Aaryland 28a-f show I at once.	5	MD NA	I	Baltim	ore					1 X Yes 2 No
Maryl:	Director	10e. Street and Number			10f. Zip Cod			1	Og. Citizen of What	
ith the Maryland 23a or 28a-f sho notified at once.		2201 Monticello				21216		<u> </u>		
tems 2	Funeral	11. Marital Status 1 Never Married 2 Married	Was Decedent Ever in U Armed Forces?	I.S. 13. W	as Decedent of Yes, specify Cu	Hispanic C Iban, Mexic	origin? (Spec an, Puerto Ri	city Yes or No ican, etc.)	White,	American Indian, Black, etc.
ter deg		3 Widowed 4 Divorced If	Yes 2 X No	1	Yes 2 X	No specia	fy:		Specify:	Black
ours af	d b	15. Decedent's Education (Specify only	Dates: nighest grade completed)	16a. Decede	nt's Usual Occi	upation (Giv	e kind of wor	rk done	16b. Kind of Busin	ness/Industry
6 172 hc	efe	Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+) 5+yrs	,	eache:) i use remed	۵,	Element	tary School
5-0036 led within 72 hours tygiene. other than "natur the Medical Exam	Completed	17. Father's Name (First, Middle, Last)	3.725				ner's Name (F	irst Middle I	Maiden Surname)	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	Jerome C. Jorda	n					teven		
ID 21215-00; should be filed with and Mental Hygiene 77 is marked other ti		46 1 (U. Nama (Ratetianabia (Tana	Print \	19b. Mailin	ng Address (S	treet and N	umber or Ru	ral Route Nur	nber, City or Town,	State, Zip Code)
and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		Joseph Parham								
ore, Mes 1 and 2 of Health If item 2		20a. Method of Disposition 1 X Burial 2 Cremation 3	_	Place of Dispo crematory or o		f cemetery,		Date		ity or Town, State
imore Pages 1: ment of H tant: If it		4 Donation 5 Other Specify:	Ga	rrisor				/2012	Owing	s Mills, Md
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	. 1	21 Sign ture of Funeral Service Licens	KI.	Ma	Name and Ago	PHOT W	ëst Ave.	Balt	imore.	Md 21215
Physician	\dashv	23a. Part I. Enter the disease, or complica	ations that daused the death							Approximate Interval
Medical		failure. List only one cause on each	line. pertensive Atherosc							Between Onset and Death
Examiner			e to (or as a consequence							
	Ļ	Sequentially list conditions, b	e to (or as a consequence	of)·						
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	e to tor as a consequence t	Ji j.						
My sand transit	Examiner	events resulting in death) Last Du	e to (or as a consequence of	of):						
ficate be executed g physician and street tree is the burial - transit		UNPENDED d.	AMENDED							
760, ficate be g physicia the buria	//Medical		23c. If yes, outcome of pre	gnancy _					23d. Date of de	elivery
687 ertifica ding p		23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of d	o oth	etal death		opic pregnano	су	Month	Day Year
Box 68 e death certil the attending ed for use as	Physicia	1 Yes 2 V No 9 Unknown	9 Unknown	eath 5 C	ther (Specify)	-				
tal Records, P.O. Box 68 cian: The law requires that the death certificate has been signed by the attending ector, page 2 should be detached for use as		Part II. Other significant conditions of	ontributing to death but not	resulting in the	underlying cau	use given in	Part I.			ute to the cause of death?
res than signed	d by	Renal Failure								Probably 4 Unknown
v requires should	Sete							24a, Was auto	osy pri	ere autopsy findings available or to completion of cause of
Che lav	Completed									ath? ✓ Yes 2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stater death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Be C	25. Was case referred to medical examiner?	nital:				ath (Check or			
Physic r this	5	1 ✓ Yes 2 No 27. Manner of Death	spital: 1	ER/Outpatier		Injury at W			Residence 6 how injury occurred	Other:
n of ding Pl h. : After e funera	ion:	1 Natural 5 Pending	(Month, Day, Year)	205. Time of	,,	Yes 2	_			
Signature of the state of the s	icat	2 Accident Investigation	28e. Place of Injury - At I	home, farm, str	eet, factory, off	ice building	, etc. 2			or Rural Route Number, City
Divinital or Italian or Italian Divinital Divi	Certification:	3 Suicide 6 Could not be determined	(Specify)					or Town,	State)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transi		(Oncon only	: To the best of my knowle	dge, death occ	urred at the tim	e, date and	place, and c	the time date	se(s) and manner a	as stated.
To the vithin To the compl	Medical	a	nd manner stated.	and/or investig		cense numb		the time, date		d (Month, Day, Year)
	2	29b Signature and title of certifier	N			.C.M.E.	201		January 13,	
U !		30. Name and address of person who co	moleted cause of death /lte	m 23a)						
~			nt Medical Examiner		Baltimore S	tr ee t, Bal	ltimore, M	D 21223		
	tate	- M.H.	32. Fi gistrar's Signa	ture.				-		
Regis	trar	JAN 1 9 20	6 Deneur		arke	_		-		
DHMH 17 Rev 1/2	2001	05 ₁₄₁		ORIGIN	AL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year Prince Patterson 12:101 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Randallstown Northwest Seasons Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 09-15-62 7. Age (In yrs. last birthday) **Funeral** 237-23-4665 Director 1**X** M 2 □ F 49 NC or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any ence. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21217 2238 Brookfield Avenue Apt.#2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. African 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: American 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade College (1-4 or 5+) B & V Company Fork Lift Opertor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Rosenberg Sarah Patterson 19a. Informant's Name/Relationship (Type, Print) Fiancee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21217Sharon Archer-Fenner 2238 Brookfield Avenue Apt.#2 Balto; MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Woodlawn Cem. Burial 2 ☐ Cremation 3 ☐ Removal from State 01-21-12 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Disease Ph_sician/ END- STAR LIVER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). that initiated events burial-trai Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death ed by the attendin detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗹 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death.

Funeral Lirector After this certificate has betely filled in by the funeral director, page 2 s autopsy performed death? 1 ☐ Yes 2 ☑ No 1 Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No **☑** Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I only one) Certifying Nurse Practitioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) nsily upahum. o. D0057463 V13/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 N 5 Rajapakse, M.O. 2835 Smith AV 5 703

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 9 2012

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ -Month 6:15 A.M Patricia Elizabeth Pindell moun Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Glen Burnie Anne Arundel Baltimore Washington Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Maryland Days July 17, 1933 1 DM 2 X F 78 215-30-9042 **Director** Usual Residence of Deceden or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director 1 ☐ Yes 2 🛣 No Maryland Prince George's Laurel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 912 Park Avenue Apt.221 20707 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examiner Armed Forces? Black, White, etc. ō 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: White If Yes, Give Year or Dates "natural", 3 Widowed 4 XDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N 10th State of Maryland <u>Administrative Asst.</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thomas L. Evans Elizabeth Hortense 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Duerr - Daughter 8036 Forest Glen Drive, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Meadowridge Mem. Park 01/18/2012 Elkridge, Maryland Funeral Service Licenses 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP M01283 7250 Washington Blvd., Elkridge, Maryland 21075 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part , E , er the diseas , or shock, or heart failure. List o each line Interval Between Onset and Death Immediate Cause (Final Physician/ neumon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 1 ☐ Yes 2 ☐ No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral ! Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Acciden
☐ Suicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cortifying Nurse Practioner: To the best of my knowledge, death on Let the time, date and place, and due to the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and a d cause of death (Item 23a) (Type, Print) 31. Da filed (Mo State

ORIGINAL

19

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e 10e Rey Fil. G923 1/24/2012 HIB th and Mental Hygiene

			amend #10e 1 - State Registrar	State of Mar	yland <i>f</i>	-	tificate of l		d Mental H	ygiene Reg. No. 2	012	01021
Ĭ			1. Decedent's Name (First, Middle, Last)	_					2. Date of D		Year	3. Time of Death
	Physici: /Medic		Louise V	LOUZe,					Se-2	Day	2212	MACOP
	Examin		4a. Facility Name (If not institution, give s	street and number)			4b. City, Town, or	r Location of D	eath	4c. Cou	unty of Death	•
age. "			Summit Par	~ /C				ons,	110	Y		more
н	Funeral		5. Social Security Number 6. Sex	7. Age]м 2[X F	(In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours N	lin. (Month, L	irth Day, Year)	Cou	place (State or Foreign intry)
	Director		212-30-9861 Usual Residence of Decedent		77				DEC.	10 193	34 M	ARYLAND
	yland III		10a. State 10b. County	1	10c. City, Tow	n or Loc	ation					10d. Inside City Limits
	a-f st	cto	MARYLAND N/A				BALTIMOR	E				1 XX es 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?
	23a	ral	4015 GORAAN AVENU	E			212	15		U.S	S.A.	
	r dea	Funeral	TT Martar otatao	Was Decedent Ev Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin' an, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)		Race - Ameri Black, White,	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ∐Yes 2 📉 No If Yes, Give		1	□Yes 2ሺNo	Specify:		Spi	ecify: BLA	CK
21215-0036	hour tural	pa pa	15. Decedent's Educ	Ye ar or Dates:	160	Deced	ent's Usual Occup	astion		16h Kind o	of Business/Ir	ndustry
 57	in 72 n "na Neolic	Completed	(Specify only highest grade	e completed)		(Give F	kind of work done of NOT use retired	during most of	working		n Dusiness/ii	iddotty
212	with giene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		DIE	TERY AID			FOOD	SERVI	CE
g	othe othe	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Midd	le, Maiden Sur	name)	
<u>a</u>	uld be Aenta rked ric ev	70 E	LEE DAVIS					JENN	IE F. HI	GH		
Maryland	as 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mantal Hygiene. I fleam 27 is marked other than "natural", or items 23a or 28a-f show filem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar man be nothered at		19a. Informant's Name/Relationship (Type	pe. Print)	191	b. Mailin	g Address (Street	and Number o	r Rural Route Num	nber, City or To	wn, State, Zi	p Code)
Σ	and 2 salth n 27 i		Deborah A. Brooks/	Daughter					Baltimore	,Maryla	and 21	216
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	amougl from State	20b. Place o	of Dispos ery, crem	sition (Name of atory or other place	ce)	Date	20c. Locati	ion - City or T	own, State
timore,	Pag ment ant: I		4 ☐ Donation 5 ☐ Other (Specify)	A TOTAL STATE	WOODL	AWN	CEMETERY	01	-21-12	BALTI	MORE, M	ARYLAND
D	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Eureral Services in the services in the services in the services are services as a service of the	Bareline		22.	Name and Addre WILLIAM 1206 W N	ss of Facility C BROWN ORTH AV	COMMUNI ENUE	TY FUN	ERAL H	OME P.A.
			23a. Part 1. unter har isease, or complishook, if heart failure. List only on	cations that caused th	ne death. Do	not ente	er the mode of dyir	ng, such as car	diac or respiratory	arrest,		Approximate Interval Between
٠,	Physician		Immediate Cause (Final	e cause on each line.	0		1 6	11.				Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence	of):	IL ES	41111				nee lo P
	Examiner											
	± 0	ner	if any, leading to immediate	Due to (or as a	consequence	of):						
	acute ind transi	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events		_							
Ö,	De execian a	Ä	resulting in death) Last	Due to (or as a	consequence	of):						
8760,	ficate be executed physician and s the burial-transit	dical	d									
×	leath certifi attending p for use as	Me	IF FEMALE:	3c. If yes, outcome of	Dreanancy							
Pox	death certif e attending d for use as	Physician/Me	in the past 12 months?	1 Live birth 2	Fetal deat		Ectopic pregnanc Other (specify)	y		23d	. Date of delimental Month	very Day Year
o Ì	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ine or death	5	Cities (specify)					
J	law requires that the dass been signed by the should be detached		Part II. Other significant conditions con	tributing to death but	not resulting	in the un	derlying cause giv	en in Part I.	23e. Die	d tobacco use	contribute to	the cause of death?
g G	uires n sigr ld be	d by	1-) you where	(60)					1	Yes 2	lo 3□ Pro	obably 4 Unknown
Records,	w req	Completed							24a, Wa	is an 2	4b. Were aut	topsy findings available
r	ا ت ک ن	ᇤ							— aut	topsy rformed?	prior to c death?	completion of cause of
	sician: The certificate rector, pag	ပိ	25. Was case referred to medical					26. Place of	1 ☐ Yes Death (Check only		1 ∐ Yes	2 □ No
5 :	Physician: this certific ral director, I	70 B	evaminer?	lospitał: 1 ☐ Inpatient	1 2 ∏ ER/O	utpatien	t 3 DOA Oth	or:	ng Home 5 ☐ Re		Other (Spec	cify)
<u></u>	g Ph terthi	盲	27. Manner of Death	28a. Date of Injury (Month, Day,	28b.	Time of Injury	28c. Injur Worl		_	e how injury or		,
VISION	ath. ath. rr: Af	Certification:	1 Natural 5 Pending 2 Accident investigation	(World, Day,	rear)	injury		Yes 2□No				
<u> </u>	r Atta	iệi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, fa	arm, stre	et, factory, office		28f. Location City or 7	(Street and Nown, State)	lumber or Ru	ral Route Number,
<u>.</u>	rs aft rs aft raid Di	è								,,		
	to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 12 Certifying Phys 2 Medical Examin	sician: To the best of ner; On the basis of e	examination a	je, death ind/or inv	occurred at the tile estigation, in my o	me, date and p opinion, death o	place, and due to the time	he cause(s) an e, date and pla	nd manner as ace, and due	stated. to the cause(s)
	o the	Mec	29b. Signature and title of certifier	and manner state			29c. Licens	e number		29d. Date s	igned (Month	n, Day, Year)
_ '	- 3 - 5					Mr) No	2		K		
		1	30. Name and address of person who co	moleted cause of des	oth (Item 23a)	(Type F	Print)	-13/				2012
	V		Deerak Bas) courain	31	155	Print) Wilke	ne A	010 [[- 10	54. HIM	21279
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	10.0	1					
	Registra	ar	JAN 192012	Canera	13. A	GASSA						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 Certificate of Death Registra 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 2012 Physician/ 8:12AM M January Evelyn Marie Rollison Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** <u>Montgomery</u> Montgomery Hospice Casey House Rockville 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral Director** 1 M 2 X 577**-**66-1430 April 8, <u>France</u> 65 Usual Residence of Deceden or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County the Maryland Director 1 Yes 2 X No Damascus Montgomery Maryland 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or Funeral United States 10009 Durango Drive 20872 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items any injury or other traumatic event, the Medical Examiner mu 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Grocery Cashier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Josephine Chelon Calvin W. Proctor 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10009 Durango Drive, Damascus, Maryland 20872 Earl B. Rollison, Jr./Husband 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State January 18, 2012 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Heaven Cemetery 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Fuperal Service Licensee M00335 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Ovarian Cancer Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Divide (or as a dunsequience of): Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month in the past 12 months?

1 Yes 2 X No
9 Unknown Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X 1 Yes 26. Place of Death (Check only one) 25 Was case referred to medical examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 K Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No injury 5 Pending 1 X Natural 2 Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 4 Homicide Medical K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar MD

32. Registrar's agnature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Wilks, M.D.

D0063195

6001 Muncaster Mill Road, Rockville, Maryland 20855

January 14, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #648 Per FH G924 2/01/2012 JH
State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Dat∈ of Death 3. Time of Death Month Year Robinson Physician/ 5:450M January 16 2012 Medical or Location of Death County of Death 4c. **Examiner** Baltimore Harbor Hospital Birthplace (State or Foreign Country) If Under 8 Date of Birth 1949 **Funeral** Months 52 4222 62 **Director** 1 M 2 - F MD Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director Ves 2 □ No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Cleveland St. items 23a 21230 U.5.4 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Medical Examiner Armed Forces Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married ģ "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other transmitted. ondary (0-12) College (1-4 or 5+) Steel Co. Be Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maide Barre St. Balto. Mu 21230 6ister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of metro Crematory or other place) Burial 2 Cremation 3 🗆 Removal from State Catonsville, mo 1 ☐ Do..... 4 ☐ Donation 5 Other (Specify) 21. Signature uneral Savice 17/14270 Fredhilton Pass Balto MU21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, to neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consecu burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 2 No 1 Yes 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending injury Natural 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 16 20/2 RESOO1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Hanover street, Baltimore, MD, 21225 Abdulghani Saadi 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 310bcc Per ANA BD G923 1/19/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January Physician/ 2012 4:46 AM Charles Joseph Rouiller Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** July 12, 1946 Days Hours Maryland **Director** 212-50-0531 1 X M 2 □ F 64 Usual Residence of Decedent 10b. County Howard 28a-f show 10d. Inside City Limits City, Town or Location **Glenelg**Glen Burnie 10a. State 10c. City, with the Maryland ms 23a or 28a-f sho must be notified at Director 1 ☐ Yes 2 🛛 No MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21737 13085 Burntwoods Rd. items 2 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Forces? 1 Yes 2 No 1967-Black, White, etc. 1 Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after white 1 ☐ Yes 2 X No Specify If Yes, Give 1968 "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) education teacher of Health and Mental Hygie If item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth Baker George Robert Rouiller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a t: If item 27 is y or other trai 13805 Burntwoods Rd; Glenelg, Maryland 21737 Janice Rouiller - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department Important: If any injury or 22. Name and Address of Facility State Anatomy Foard Sign rector 655 W. Baltimore St; Baltimore, MD 21201 Ronald Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Month disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Errier Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No ed by the a detached f Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown director, page 2 should peen 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performed? has 2 No 1 Yes 2 No certificate 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Normalize} \) Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Watural 5 Pending injury 1 🗌 Yes 2 🔲 No Accident Investigation within 24 hours after death

To the Funeral Director:

completely filled in by the 6 ☐ Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARIATHT KUMAR 31. Date filed (Month, Day, Year)

JAN 19 2012 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Time of Death Wilbur O. Redmiles ^{Day}2012 Physician/ 3:10 A January 17 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice 9. Birthplace (State or Foreign MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 30,1914 **Funeral** 1XX M 2 □ F Months Days Director 218-03-0294 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1XX Yes 2 □ No MD N/A **Baltimore** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò must be Funeral 23a U.S.A. 21211 4230 Falls Road ral", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2XX No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify: Specify: White 3 Widowed 4XX Divorced "natural" Completed Il Hygiene. I other than "natura vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Roofer event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked or traumatic ever ဂ္ Ida Mae Wheeler Robert Redmiles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 3720 <u>Chestnut Avenue Balto, MD 21211</u> Charles Redmiles (Son) 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestiawn Menorial 1/23/2012 Marriottsville, MD Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Funeral Service See 22. Name and Address of Facility Durget 13631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Dreumoni-Prevencion/ weeks disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or liniury certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Drastate concer Mact 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 27 Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 \square Pending 1 Yes 2 No Accident Suicide Investigation within 24 hours after deatl

To the Funeral Director:,
completed filled in by the 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one

Registrar DHMH 17 Rev 7/2009

State

ρ

nd title of certifier

31. Date filed (Month, Day, Year)

JAN 19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

parke

D58303

6701 N. ChanGo ST TONSONM

29d. Date signed (Month, Day, Year)

17 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 1:00A Sylvester Franklin Simmons January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Manor Care Dulaney Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 307-24-1370 **Director** 1 🖾 M 2 🗆 F Yrs Dec. 9,1927 84 Indiana Usual Residence of Deceder ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 🔀 Yes 2 🗆 No Mary.land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6724 Glenkirk Road 21239 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic 8th grade Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill the should be fill the should be 2 Eugene Simmons Sarah Soules 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6724 Glenkirk Road Baltimore, MD 21239 Wanda Jean Simmons-Clemmons 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cem. Owings Mills,MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home any 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheros lenst. Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Duis to for an a Chrisquishna of cause. Enter Underlying Cause (Disease or injury that initiated events Exam resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

68760 BOX P.O. Records, the Hospital or Attending Physician: Division of Vital

29b. Signature and title of certifier 1731865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 182 206 32. Registrar's Signature JAN 1 9 2012 Registrar

(Check only one

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan Day 2012 Physician/ Schlerf 7:15A Thelma V. 19 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster 93 Bond St. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday Funeral Months Days Hours 219-20-1425 85 Director 1 🗆 M 2 🗶 F Yrs 10-12-1926 PA Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location must be notified at Director 28a-f Carroll Westminster 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number Funeral 23a 93 Bond St. 21157 USA ural", or items? death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural" Completed 3 ☑ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Education of Health and Mental Hygier fitem 27 is marked other I r other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Melvin Garrett Mimi Spangler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Westridge Circle, Mt. Airy, MD 21771 Diana L. Poque-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 = 9 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 1-23-12 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch 22. Name and Address of FacilityFletcher Funeral Home 21. Sign at a Survice License 1. tohlen homas Main St., Westminster, MD 21157 254 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 as the k IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown a | Ilnknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an funeral director, page 2 autopsy performed death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the F only one 29d. Date signed (Month, Day, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year)
JAN 1 9 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Marylan	-	artment of H tificate of D			g. No. 20	12 01028
	Physicia Medic	n/	4 Decedentia Nama (First Middle Dot)	smith				2. Date of Death Month		3. Time of Death
	Examin		4a. Facility Name (if not institution, give stre	eet and number)		4b. City, Town, or			4c. County of	Death 1timore
S	Funeral		Seasons Hospice 5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	Randal If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birthplace (State or Foreign Country)
	Director		212-34-5139 1 ☐ Usual Residence of Decedent	м 2 🗓 7	5 Yrs.			11-29-19		MD
	yland -f shov ed at	ctor	10a. State 10b. County		y, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 🛣No
	he Mar or 28a	Dire	MD Baltimore 10e. Street and Number	<u> </u>	ings Mi.	10f. Zip Code		10	Og. Citizen of Wh	
	s 23a nust be	Funeral Director	9811 Linden Hill Road				1117		USA	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	"	Vas Decedent of His f Yes, specify Cubar I ☐ Yes 2 🙀 No	n, Mexican, Puerto	cify Yes or No- Rican, etc.)	Black,	- American Indian, White, etc. African-American
15-0	72 hou n "natu Iedical	nplet	15. Decedent's Educ (Specify only highest grade	completed)	(Give I	dent's Usual Occupa kind of work done d O NOT use retired)	ation uring most of workl	ng	16b. Kind of Busi	iness/Industry
212	within giene. er tha		Elementary/Secondary (0-12)	College (1-4 or 5+)		ekeeping			Mt.Wilson	State Hospital
and	be filed ental Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	,	aiden Surname)	
aryl	should be file h and Mental 7 is marked c traumatic eve		George Cager 19a. Informant's Name/Relationship (Type	, Print)	19b. Mailin	ng Address (Street a	Trene Ca		City or Town, Sta	te, Zip Code)
S,	and 2 s Health s em 27 i		Angela Wilson/ Daughter 20a. Method of Disposition			Linden Hil				
Baltimore, Maryland 21215-0036	Page 1 ament of hant: If ite		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cren	sition (Name of natory or other place metery	1-21-2	2012 V	wodlawn,	
Ball	permit. Departr Imports any inji		21. Signati or bintral Service Cicenson			2. Name and Addres 200 Liberty				A. of Balto. Co.
			23a Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat cause on each, ine.	_			or respiratory arres	st,	Approximate Interval Between Onset and Death
ų.	Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		2000	e			
	Examiner	Į.	Sequentially list conditions, b.	-						
· gr	ted d ansit	Examiner	if any, leading to immediate Cause (Disease or injury	Due to (or as a consequ	Jence of):					
20	cate be executed physician and s the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
3760	ficate by physical physical physical graphysical graphysical graphysical physical ph	Medical	d.		0.77				115-15-1	
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of of 9 Unknown	al death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mont	of delivery th Day Ye ar
ds, P.O.	quires that the signed by and be detail	þ	Part II. Other significant conditions cont	ributing to death but not res	sulting in the u	inderlying cause giv	ren in Part I.			oute to the cause of death? B Probably Unknown
Division of Vital Records,	: The law red cate has ber r, page 2 sho	Completed							y pr ned? de	ere autopsy findings available for to completion of cause of eath?
Vital	ysician; The s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	ER/Outpatier	Othe	ace of Death (Checker: 4 Nursing Ho	ome 5 Reside	nce 6 Other	age Signico
on of	ttending Physideath. ctor: After this y the funeral di	Certificate: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	/ at	28d. Describe ho		
Division	al or Attend s after death		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, factory, office		28f. Location (Str City or Town,	eet and Number , State)	or Rural Route Number,
_	To the Hospital or Attending Physician; The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check 2 Medical Examine	ian: To the best of my know r: On the basis of examinatio Practitioner: To the best of	n and/or inves	tigation, in my opinic	on, death occurred a	t the time, date and	d place, and due t	to the cause(s) and manner stated.
	To the vithing of the contract		29b. Signature and title of certifier	1/2-	n	29c. License	number	2		(Month, Day, Year)
	A		30. Name and address of person who con	npleted cause of death (Item	23a) (Type, F	Print)	11/		14n /	6,2012 21061
	9 1		Maro LA BO	32. Registrar's Signa	Aur	4 d'ay	19100	Hen B	RURGI	21061
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 9 2012	32. Hegistrar's Signa	arked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Ann Fullam Steele 7:20 AM Physician/ January 14, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery 7512 Cayuga Avenue Social Security Numbe If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 578-44-0387 76 **Director** 1 □ M 2 🏻 F Aug. 13, 1935 Washington, D.C. Yrs Usual Residence of Decedent 28a-f show Should over Hygiene.
and Mental Hygiene.
f is marked other than "natural", or items 23a or 28a-f shot
f is marked other than "natural" at items 23a or 28a-f shot 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 No Bethesda Maryland| Montgomery 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral United States 20817 7512 Cayuga Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Statistical College (1-4 or 5+) Elementary/Secondary (0-12) Logistician Research Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Richard Fullam Marie Griffith permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7512 Cayuga Avenue, Bethesda, Maryland Bruce E. Steele, Sr./Husband 20b. Place of Disposition (Name of Montgomery crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 18, 2012 1 Burial 2 Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 M00198 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 9 Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 28b. Time of 28d. Describe how injury occurred After 1 🔀 Natural 5 Pending 2 No Accident Investigation after death Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Division of Vital Records, within 24 hours a

To the Funeral D

completely filled

State Registrar

Medical

29a. Certifier

(Check

29b. Signature an

Leon C. Hwang, M.D. 31. Date filed (Month, Day, Year) JAN 19 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1396 Piccard Drive, Rockville, Maryland

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D45880

29d. Date signed (Month, Day, Year)

January 17, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	,	1 - For State Registrar 1. Decedent's Name (First, Middle, La			epartment of F Certificate of L		/lental Hy	Reg. No.	12	0 1 0 3 0 3. Time of Death
Physici Medi Exami	ical	Donna 4a. Facility Name (if not institution, giv	Lynn re street and number)	Steffe		r Location of Death	Month Januar	y 14, 20 4c. County	Year 12 of Death	8:32 P ^M
		4308 War	ner Street		Kei	nsington		Mo	ntgo	mery
Funeral	_	Social Security Number 6.3	Sex 7. Age ('In yrs. last birthd	ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		g. Birthpi Count	lace (State or Foreign ry)
Director		213-54-8707 Usual Residence of Decedent	1 □ M 2 🗓 F	64	3.		October	22, 1947	Washi	ngton, D.C.
and show	þ	10a. State 10b. County	1	10c. City, Town o	r Location		-		10	d. Inside City Limits
Maryl 28a-f otifiec	rect	Maryland Montg	gomery		K	ensington				1 🗌 Yes 2 💢 No
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 4308 Warr	ner Street		10f. Zip Code	20895		10g. Citizen of V	Vhat Count	
death item	F	11. Marital Status	12. Was Decedent Eve Armed Forces? 1 Yes 2 X No	er in U.S.	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Blace	e - America k, White, e	
Baltimore, Maryland 21215-0036 oermit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. mportant if item 27 is marked other than "natural", or any hijury or other traumatic event, the Medical Examinance.	ted by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	0	1 Yes 2 X No	Specify:		Specify:		
15-(72 hour "nat	Jple	15. Decedent's (Specify only highest g	Education urade completed)	(G	ecedent's Usual Occup live kind of work done of	during most of work	ing	16b. Kind of Bu	usiness/Ind	lustry
ithin ene.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)) ///	e. DO NOT use retired) Realto			Rea1	Esta	te
nd 2	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surname	9)	
/lar d be f Menta Menta arked	ြို	James D.	Kemper			Γ	orothea	a Wailes		
lary should and h is ma		19a. Informant's Name/Relationship (Type, Print)	1.71	failing Address (Street					
ind 2 health		Sandra K. Lav	ery/Sister		04 Logan Di	rive, Pot	omac, M			
DOC ge 1 a nt of F i. If ite or ot		20a. Method of Disposition 1 X Burial 2 Cremation 3		20b. Place of D	isposition (Name of crematory or other place United Metho		ary 19,	20c. Location -		
Itin		4 Donation 5 Other (Spec		Church	Cemetery		012	Potomac		
Derm Department of the concession of the concess		21. Signature of Funeral Service Licer	me		Robert A. Pur 7557 Wiscons				Ch e vy 20814	Chase, Inc. -3501
		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the one cause on each line.	he death. Do not	enter the mode of dyin	g, such as cardiac	or respiratory ar	rrest,		Approximate Interval Between
- Physician		Immediate Cause (Final disease or condition resulting in death)			Small Cell	Lung Car	ncer			Onset and Death 8 Months
Medical Examiner		resulting in deathy	Due to (or as a d	consequence of):						
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence of):						
nted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6							
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	al Ex	resulting in death) Last	Due to (or as a c	consequence of):						
760 cate b physii	edical		d							
ords, P.O. Box 687 requires that the death certific. been signed by the attending preshould be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		. □ .			23d. Da	te of delive	ery
30x death e atte	sicia	in the past 12 months? 1 Yes 2 X No	1 Live Birth 2 4 Pregnant at t 9 Unknown		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy		Мо	nth	Day Year
D. E. the charteners that the	hys	g 🗌 Unknown								
requires that the been signed by t	by	Part II. Other significant conditions	contributing to death but	not resulting in t	he underlying cause gi	ven in Part I.				e cause of death?
rds equire	ted						1 🔼			pably 4 Unknown
Division of Vital Records, rat or Attending Physician: The law requires s after cleath. al Director: After this certificate has been signed in by the funeral director, page 2 should b	Completed						24a. Was	psy	Were autor prior to cor death?	osy findings available mpletion of cause of
ital Recosician: The law certificate has irector, page 2							1 Tes		1 Yes	2 🗆 No
ital sician certifi	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	Hospital:		_ Oth	lace of Death (Chec				
Physeral di	년 -	27. Manner of Death	28a. Date of injury		atient 3 L DOA	4 ☐ Nursing H		dence 6 Other)
on C ading ath. : Afte	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, 1	Year) inju	ry work	⟨? Yes 2 □ No		,,		
isic Atter or dea ector by th	Certificate:	3 Suicide 6 Could not	be 28e. Place of Injury		, street, factory, office			Street and Number	er or Rural	Route Number,
Div talor rs afto al Dir led in		0	building, etc.	(Specify)			Gity or To	wn, State)		
Hospi 4 hou Tuner tely fill	Medical	29a. Certifier 1 X Certifying Ph (Check 2 Medical Exam	ysician: To the best of m niner: On the basis of exa	y knowledge, de mination and/or in	ath occurred at the time	e, date and place, a	nd due to the c	ause(s) and manr and place, and du	ner as state e to the cau	ed. use(s) and manner stated
Division of Vital Reco	Me	only one) 3 Certifying Nu 29b. Signature and title of certifier	rse Practitioner: To the b	pest of my knowle	dge, death occurred at 1	the time, date and pl	ace, and due to	the cause(s) and n	nanner as s	stated.
₽ ½ ₽ 8		235. Signature and the or certifier	11/11/18	_				Januar		
•		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Tur		33293		Januar	у 10,	2012
20		Frederick Smith				#1300, C	hevy Ch	ase, Mar	y1ano	1 20815
Sta	ite	31. Date filed (Month, Day, Year)	82. Registrar's	s Signature						
Regist	rar	JAN 1 9 2012	Senetra	1. 100	ald					
DHMH 17 Rev 06	-2011									
1				0.014	O I A I A I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Janina Ann Sanders January 13, 4:59 A M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 578-50-9649 Director 96 1 M 2 X F Poland Poland June 24, 1915 Usual Residence of Decede ms 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3902 Gannon Road 20902 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ori 1 Never Married 2 Married þ 1 ☐ Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home Homemaker Ath and Mental Hyorical is mark Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file if Health and Mental H item 27 is marked or other traumatic eve ျ Constanine Schnip Paulina (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicholas Sanders/Husband 3902 Gannon Road, Silver Spring, Maryland 20902 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1
Department of
Important; If it
any injury or o ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Parklawn Memorial January 2012 19, Rockville, Maryland 4 Donation 5 🗷 Other (Specify) Entombment 21. Signature of Funeral Sprice Licensee Robert Addressiful Funeral Home/Rockville, Inc. M00198 300 West Montgomery Ave., Rockville, Maryland 20850 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Unknown shock, or heart failure. List only one cause on each line Immediate Cause (Final Ischemic Coronary Artery Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury Examine Due to (or as a consequence of): the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death by the signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No this certificate 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 X No Certificate: To 1 ☐ Inpatient 2 🛛 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 06-2011

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

your a.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yuri A. Deychak, M.D. 6410 Rockledge Drive, #200, Bethesda, Maryland

82. Registrar's Signature

29c. License number

D0041311

January 16, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11021 Physician/ January 201 Medical 4a. Facility Name (if not institution, give street and number) Town or Location of Death 4c. County of Death Examiner 4b. City Baltimore N/AHO If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Sept. 9 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. Maryland 53 Yrs 220-74-1711 1958 Director Sept. Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10a, State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No notified Baltimore City Maryland N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 must be 23a Funeral 21230 838 Washington Blvd. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 9 þ 1 Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates. 1 ☐ Yes 2 XNo Specify: "natural" 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Infra-Metal Inc. the Jockey Trailer 10grade t. Page 1 and 2 should be filed with theent of Health and Mental Hygien trant: If item 27 is marked other 1 njury or other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Myrtle Thompson 17. Father's Name (First, Middle, Last) မ William Howard Shriver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 838 Washington, Blvd., Baltimore, Maryland 21230 Pamela M. Shriver/ Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once. Brooklyn Park, Maryland Jan. 18, 2012 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility AMBROSE FUNERAL HOME OF LANSDOWNE 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 Signature of Fundal Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hiver Ta1 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 Live Leanne of death in the past 12 mg 1 Yes 2 Y Day Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed Yes 2 X Division of Vital Be 25. Was case referred to predical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 NER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) မြ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 🗌 Yes 2 🗌 No death. Accident Investigation s after death Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Emergency Departners. License number 29d. Date signed (Month, Day, Year) Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. HANDUER STREET, BALTIMORE BARNES 3001

DHMH 17 Rev 7/2009

State Registrar 12-00388

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

•	2	0	-	2	0	-	0	3	-
	Stume	400	2		-		4.00		

Villiam M. Stein		1- For State Registrar	ate of Maryland /		artment of <i>rtificate of</i>		and	Menta	al Hy		Reg. No.	20	10	2 0103.
Physicia Medical Exami		Decedent's Name (First, Middle							2	2. Date of De Month January	ath Day	Year		3. Time of Death 0754 hrs
)		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore												
Funeral			6. Sex 7. Age	(In yrs.	last birthday)	If Under		If Under		8. Date of B	irth (MM			nplace (State or
Director			1XXM 2 F		82 Yrs.	Months	Days	Hours	Min.	May 3	, 19		Foreigr Cou	ntryMaryland
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locati	on								10d. Inside City Limits
Maryland 28a-f show 1 at once.	tor	Maryland Baltimo	ore	Arb	utus			_			10 0"			1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	10e. Street and Number 1232 Vogt Ave.				10f. Zip Co					-	izen of What ted S1		-
th with cems 23 of be no	Funeral	11. Marital Status 1 Never Married 2 Mar	12. Was Decedent Armed Forces?	Ever in U		Decedent es, specify (cify Yes or N ican, etc.)	0-	14. Race White,		an Indian, Black,
ufter des	by Fui		1 Yes 2 rced If Yes, Give Year or Dates:	ΧXνο	1	Yes 2X	No No	specify:				Specify:	W	hite
hours a		 Decedent's Education (Speci Elementary/Secondary (0-12) 	fy only highest grade com College (1-4 or 5		16a. Decedent during mo	's Usual Do st of workin					16b.	Kind of Busin	ness/Ir	ndustry
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	7th			Truck	Driv						anspo	rta	tion
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatie event, the Medical Examiner must be notified at once	Be Co	17. Father's Name (First, Middle, L Elmer Stein	.ast)					3.Mother's Mari		First, Middle,	Maiden	Surname)		
ID 21215 should be fill and Mental H 77 is marked	T _o	19a. Informant's Name/Relationshi John Stein /Son	ip (Type, Print)		19b. Mailing		Street	and Numbe	er or Ru	ral Route Nu				Zip Code)
imore, MD Z Pages 1 and 2 shou ment of Health and N tant: U feen 27 is on m other traumatic		20a. Method of Disposition	• 🗆 -		Place of Disposi crematory or oth	tion (Name				Date		Location - C		Town, State
Baltimore, permit. Pages 1 a Department of He Impartant: If ite		1 Burial 2 Cremation 4 Donation 5 Other Spe	ecify:	10	dar Hil	1 Cem								rk,Maryland
Baltimo permit. Page Department of Important: injury or ott		21 onat r of Funeral Service L	Stanto-		132	ame and Ad	^{Idress} o phui	f Facility Spr	MBR(ing	Rd.,A	NERA rbut	L HOM	E,I	NC and 21227
Physician /Medical		23a. Part I. Enter the disease, or c failure. List only one cause of	omplications that caused to each line. Acute	he death Bron	chopneur	e mode of o	dying, su	ich as care	diac or r Lain	espiratory ar	rest, she	ock, or heart nsive		Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. heart dis	_									-	Death
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence o	of):	-								
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence o	of):								-	-
3 43	al Exa	.	d	nt '	TT 27 ne	T MA	σ Q 2	5 3_1	-12	cm		_		
be be	Medical	IF FEMALE:	23c. If yes, outcom			I me,	672		12		23	d. Date of de	elivery	
Box 6876(death certificate the attending physical for use as the b	jā.	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at t	ime of de	noth -	al death er (Specify	3 [Ectopic p	regnand	Э		Month	D	ay Year
the death the by the att	Physic	1 Yes 2 No 9 Unkn	9 Unknown	h. d nat n				on in Dark		230 Did	tobacco	use contribu	to to t	ne cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	ğ	Dementia; Chron			-		-		'. 		_		,	ably 4 Unknown
cords, law requii	Completed									24a. Was	psy	pric	or to co	opsy findings available ompletion of cause of
Vital Rec ysician: The la his certificate h director, page 2		25. Was case referred to medical				26	Diaca o	f Death (C	back on	1 ✓ Yes	ormed? 2 N		eth? Yes	2 No
Vital Rechysician: The this certificate	eg e	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 🗌	ER/Outpatient					Home 5	Reside	ence 6	Other:	
nding Ph nding Ph th. : After ti e funeral	ion: T	27. Manner of Death 1 X Natural 5 Pendir	28a. Date of Injur (Month, Day,Ye		28b. Time of In			at Work? s 2 N		8d Describe	how inj	ury occurred		
ivisior or Atteno ufter death Director: in by the	Certification	2 Accident Investi 3 Suicide 6 Could	not be 28e. Place of Inju	ury - At h	ome, farm, stree	t, factory, of	fice bui	lding, etc.	2	8f. Location or Town,		and Number	or Rur	al Route Number, City
Di lospital 4 hours a 'uneral]		4 Homicide determ	nined (Specify) /sician: To the best of my	knowled	ne death occur	ed at the tin	ne date	and place	and di			nd manner a	s state	d .
Division of Vital Records, P.O. Box 6876. To the Bospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	Medical	one) 2 Medical Exam	Iner: On the basis of exam and manner stated.		-	on, in my op	oiníon, d	leath occu			and pla	ace, and due	to the	cause(s)
	Σ	29b. Signature and title of certifier	200				icense r D.C.M.				1	Date signed uary 14,		th, Day, Year)
	ŀ	30. Name and address of person w												
	ata	Patricia Ardnica-Pollak 31. Date filed (Month, Day, Year)	MD. Assistant M	s Signatu	Examiner 9		altimo	ore Stre	et, Ba	Itimpre, M	1D 212	223		
Regist	_	JAN 1 9 201		A	park									

DHMH 17 Rev 1/2001 OCME 2006

			For State	-	partment of Health and	Mental Hygien	e 0012 0102
			Registrar 1. Decedent's Name (First, Middle, Las		ertificate of Death	Reg. N	lo. 2 J J J J 3. Time of Death
	Physicia Medic	al	Willie M.	Stevens		Month D	06 2012 03,19 M
	Examin	er	4a. Facility Name (if not institution, give		4b. City, Town, or Location of Deatl BALTIMORE, M		lc. County of Death
11	Funeral Director		5. Social Security Number 6. Se		y) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign
	d now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location	VIHY DU 12	10d. Inside City Limits
	larylar 3a-f sk ified a	ecto	MD NIA	Baltima			JETYes 2 □ No
	the M	اقًا	10e. Street and Number	-	10f. Zip Code		Citizen of What Country?
	h with	Funeral Director	5628 Midwoo		21212	US	
396	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	 Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puert Yes 2 No Specify: 		14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	hours hatur dical E	olete	15. Decedent's Ed (Specify only highest gra	lucation 16a. De	cedent's Usual Occupation ve kind of work done during most of wor	king 16b.	Kind of Business/Industry
121	hin 72 ne. than "	mo	Elementary/Secondary (0-12)		. DO NOT use retired)		elf Employed
	led within Hygiene. other tha ent, the N	Be C	17. Father's Name (First, Middle, Last)	Har	18. Mother's Na	ne (First, Middle, Maider	n Surname)
ılan	ild be file Mental narked c	2	Willie Stevens		Julia 1	4. Malone	
Maryland	should and N is ma rauma		19a. Informant's Name/Relationship (Ty	11160	ailing Address (Street and Number or Ru		
	and 2 Health :em 27		CUTHERINE STEVER 20a. Method of Disposition		R8 Midwood Ave		D 31313 Location - City or Town, State
Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra		1 Durial 2 Cremation 3 4 Donation 5 Other (Specification)	Removal from State cemetery, completely, c	rematory or other place) Pematory 1-13	1	tonsville, mo
Ba	permit Depar Impor any in once.		21. Signature of Funeral Service Licens	ee	22. Name and Iddress of Facility	10 Fredhillon A	Pass Balto. Mo 21229
			23a. Part 1 Enter the disease, or comp shock or heart failure. List only or	ligations that sourced the death. Do not a	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
æ.,	Physician/		Immediate Cause (Final disease or condition	a. CARDIO VASCU U Due to (or as a consequence of):	AR ARKEST		Onset and Death
and a	Medical Examiner		resulting in death)		- Aller San		Naus
	. 6.6	Jer.	Sequentially list conditions, if any, learning to innicolate cause. Enter Underlying	b. SEPSIS			- Jugs
B	uted id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· MULTIORGIAN	FAILURIF		Weeks
7	ate be executed ohysician and the burial-transit	al E	resulting in death) Last	Due to (or as a consequence of):			
760	cate be physic	edical		d			
. Box 68760	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
P.O.	that the	y P	•	intributing to death but not resulting in th	, , ,		use contribute to the cause of death?
ds,	quires en sig ould b	ted b	A. fibrillahan,	Pulm Embolica Puemonia, 4	n, CHF,	1 🗆 Yes	2 No 3 Probably 4 Unknown
Division of Vital Records,	The law re ate has be page 2 sh	Somple	ASPIRATION	Premonia, 1	ridney failure	24a. Was an autopsy performed?	
ta	ician; certific ector,	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death (Che	ck only one)	
of V	r this eral di	6: 일	27. Manner of Death	Inpatient 2 ER/Outpa	e of 28c. Injury at	lome 5 Residence 28d. Describe how inju	
ou o	ath. rr. Afte	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injur	y work? M 1 🗆 Yes 2 🗀 No		,
Division	al or Atte s after de al Directo ed in by th	Certif	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
_	To the Hospital or Attending Physician; The law within 24 hours after death. To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2	Medical Certificate:	(Check 2 Medical Exami	ician: To the best of my knowledge, dea ner: On the basis of examination and/or inv e Practitioner: To the best of my knowled	vestigation, in my opinion, death occurred	at the time, date and place	ce, and due to the cause(s) and manner state
	North Voilt		29b. Signature and title of certifier	MD	29c. License number IRES 000		Date signed (Month, Day, Year)
	5		30. Name and address of person who control Nutan, No	ompleted cause of death (Item 23a) (Type . S609, G00D SMM)	e, Print) PRITAN HOSPITAL,	BALTIME	DRE MD 21239.
	Sta Registra	e ar	31. Date filed (Month, Day, Yard) 2 JAN 1 9 2012	SGO 9, GOOD SATTY 32. Registrar spignatural			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Simmont 18:27 Alfred 2012 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk 3445 Yardley Drive 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign Funeral Davs Hours Director 1**X** M 2 □ F 217_14_5828
Usual Residence of Decedent March 26,1923 Maryland Yrs. 88 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location items 23a or 28a-f sho her must be notified at Director Dundalk 1 Yes 2 No Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21222 USA Funeral 3445 Yardley Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Xes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 0 1 Never Married 2 Married ģ Maryland 21215-0036 nan "natural", o Medical Exan 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) event, the Western Electric 4 years Warehouseman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Simmont Margaret Smith traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13 East McClure, New Bloomfield, PA. 17068 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Daughter Kathryn Dorundo Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of January cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland Bayview Crematory 17, 2012 ature of Everal Service Licens Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of thing, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final unan Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading of three-late cause. Enter Underlying Examine Dia to (or as a consequence of) the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical funeral director, To Be 26 Place of Death (Check only one) Other: 2 No 1 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne eath 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending ☐ Accident Investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely

201 State

within 24

Registrar

DHMH 17 Rev 06-2011

only one)

29b. Signature and title of cert

30. Name and address of per

lled (Month, Day, Ye N 1 9 2012

who completed cause of death (Item 23a) (Type, Print)

730 32. Registrar's Signature

parel

29c. License number

29d. Date signed (Month, Day, Year)

Dundalk, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 _ State	Department of Health and Machinery of Death		2012 01036
	8	Registrar 1. Decedent's Name (First, Middle, Last)	Octimicate of Beatif	Reg. No. 2. Date of Death	3. Time of Death
Physic Med		Patricia A. Scarlett		01 08 Day	2012 1317 M
Exam		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		ounty of Death
		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birt)	Silver Spring If Under 1 Year If Under 24 Hrs.	8. Date of Birth	ntgomery 9. Birthplace (State or Foreign
Funera Directo		1/67-76-5020	Months Days Hours Min.	(Month, Day, Year)	Country)
ow t	٦.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town		08/29/1946	10d. Inside City Limits
arylan a-f sh fied a	cto	MD Montgomery Silve:			1 X Yes 2 No
the Ma or 28 e noti	ä	10e. Street and Number	10f. Zip Code	10g. Citize	en of What Country?
s 23a	Funeral Director	13316 Sherwood Forest Drive	20904	USA	
death r item ner m		11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	1. Race - American Indian, Black, White, etc.
336 s after al", o	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Year or Dates,	1 ☐ Yes Ž EX No Specify:	Sį	pecify: Black
5-00 hours matur	Completed		Decedent's Usual Occupation (Give kind of work done during most of work)	16b. Kind	d of Business/Industry
hin 72 Pe. Than "	J Wo	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO NOT use retired)		£ E1
d 2 ed wit Hygie officer	Be C	17. Father's Name (First, Middle, Last)	ner of Daycare Cente	e (First, Middle, Maiden Su	f Employed
lan be fill lental rked o	P	Bill Gray, Sr.		ckey Jones	, name
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	10		. Mailing Address (Street and Number or Rura	l Route Number, City or To	own, State, Zip Code)
			4832 Melfordshire Way		
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or othe		1 Purial 2 V Cramation 2 Permayal from State cemeter	y, crematory or other place)		ation - City or Town, State
Baltimor permit. Page 1 Department of I Important: If it any injury or of		4 Donation 5 Other (Specify) Metro	politan Cremato 01/1		
Balt permit. Departr Imports any inje		Ant C. ballen	4217 9th St. NW Was		
		23a part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac c	or respiratory arrest,	Approximate Interval Between
~ Physician		Immediate Cause (Final disease or condition Pneumonia			Onset and Death
Medica Examine		resulting in death) Due to (or as a consequence of Metastatic Lun	*		
₽°	je je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	×		
executed an and rial-transit	Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events c.			
'ISION Of VITAL RECONDS, P.O. BOX 68/60 Attending Physician: The law requires that the death certificate be executed er death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	ical E	resulting in death) Last Due to (or as a consequence of	rf):		
/60 cate b physic	edic	d			
certificate anding phy use as the	In/M	IF FEMALE: 23b. Was decedent pregnant in the post 12 postbo2 1 ☐ Live Birth 2 ☐ Fetal death	2 🗆 Estadia avenue	23	3d. Date of delivery
Box death c he atten	Physician/Med	in the past 12 months? 1 Yes 2	5 Other (specify)		Month Day Year
that the ned by the detach	Ph	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?
Kecords, P.O, The law requires that the ate has been signed by ti	d by	Severe Malnutrition		1 ☐ Yes 2 ☐	No 3 Probably 4 Lunknown
VITAI KECOTGS, ysician: The law requires is certificate has been sig	Completed			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Hec The lay ate has	E O		,	autopsy performed? 1 Ves 2 No	death? 1 Yes 2 No
tal cian:	Be	25. Was case referred to medical examiner?	26. Place of Death (Check		
Physi Physi this c	은	1 Pes 2 D No 1 Inpatient 2 ER/Ou		me 5 Residence 6 28d. Describe how injury	
on o	cate		njury work? M 1 \sum Yes 2 \sum No	28d. Describe now injury (occured
DIVISION OT tal or Attending Phrs after death. In Director: After the death of the the death.	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street and I	Number or Rural Route Number,
Dital o				<u> </u>	
DIVISION Of VITAL To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, ((Check 2 Medical Examiner: On the basis of examination and/o only one) 3 Certifying Nurse Practitioner: To the best of my know	r investigation, in my opinion, death occurred at	the time, date and place, a	and due to the cause(s) and manner stated.
To the within To the comp	2	29b. Signature and title of certifier	29c. License number		signed (Month, Day, Year)
		Dung, m. D.	D66249	01/0	08/2012
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) est Glen Rd. Silver	Spring MD	20010
St	ate	Jonathan Duran, MD 1500 For 31. Date filed (Month, Day, Year) 32. Registrar's Signature		phring, Em 7	-0/10
Regist		JAN 19 2012 Server p. 19			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01 2012 0042A Richard Stewart Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince Georges Hospital Chever1v Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Hours Min Director 240-44-4334 1 XM 2 □ F Yrs 03/08/1932 NC Usual Residence of Decedent 28a-f shov must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Hyattsville 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4825 Lasalle Rd. 20782 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. er than "natural", or ite the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify If Yes Give Specify: Black 3 XWidowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Professional Pallbearer Business Owner other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ Unknown Annie Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i Ernest T. Bess/Nephew 377 Bryerstone Dr. Willow Spring, NC 27592 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 01/13/2012 Riverdale, MD 21, Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home anet 4217 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ PNEUMONIA WITH RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to Escan a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical requires that the death certificate be Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy ō in the past 12 months? Month Pregnant at time of death Other (specify) 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ALTERED MENTAL STATUS 2 XNo 3 Probably 4 Unknown 1 Yes CARDIO MY OPATHY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an • Hospital or Attending Physician: The law r 24 hours after death.
• Funeral Director: After this certificate has b autopsy perform RENAL FAILURE ACUTE 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 29b. Signature and title of certifier 29c. License number MO 29d. Date signed (Month, Day, Year, D69196

State Registrar

DHMH 17 Rev 06-2011

HOSPITAL DRIVE

CHEVORLY, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINGH

JAGDEEP

2001

32. Registrar's Signature

98760	
Box (
, P.O.	
Records	
of Vital	
Division	

				e or Print in Black Inde							
		-	_ State	ate of Maryland / Departi	ment of Health i icate of Death		reg. No. 2012	01038			
			1. Decedent's Name (First, Middle, Last)	Ocitin	Toute of Doutin	2. Date of Dear	th	3. Time of Death			
	Physicia Medic		Dorothy Anna Schultz			Januar	7 16 2012	735 PM			
	Examin	er	4a. Facility Name (if not institution, give street		City, Town, or Location of		4c. County of Deat	h			
nas di	Funeral	0	5. Social Security Number 6. Sex								
	Director		217-09-7948 1 □ M Usual Residence of Decedent	2X F 94 Yrs.	onths Days Hours	Apr. 24		Maryland			
	show d at	tor	10a. State 10b. County	10c. City, Town or Location	on			10d. Inside City Limits			
:	28a-f	irec	MD Baltimore	Lutherville			10 00 00 00 00 00 00 00 00 00 00 00 00 0	1 Yes 2 No			
:	vith the 23a or st be i	ral	101.5 Chastrut Dides		10f. Zip Code 21093		10g. Citizen of What Co	untry?			
:	leath v Items er mu	Funeral Director	A	as Decedent Ever in U.S. 13. Was	Decedent of Hispanic Ori s, specify Cuban, Mexican	igin? (Specify Yes or No-	14. Race - Ame Black, White				
36	after d I", or i xamin	þ	1 Never Married 2 Married 1	☐ Yes 2 X No Yes, Give 1 ☐	Yes 2 X No Specify.		Specify: 1	ite			
00-	hours natura lical E	Completed	15. Decedent's Education		's Usual Occupation	t of wording	16b. Kind of Business/				
215	hin 72 ne. than " l e Mec	dmo		ollege (1-4 or 5+)	l of work done during mos OT use retired)	at of working	Education				
d 2	ed wit Hygie other ent, th	Be C	12 17. Father's Name (First, Middle, Last)	5+ Teacher		er's Name (First, Middle, I					
/lan	d be fii Mental arked atic ev	욘	Philip Strohecker		Ann	a Kuna Gunda	a Hammond				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Be any injury or other traumatic event, the Medical Examiner must be notified at once.	7	19a. Informant's Name/Relationship (Type, Pr		Address (Street and Number						
<u>.</u>	l and 2 f Healtl item 2 other t		Melvin J. Schultz, S	20b. Place of Disposition	on (Name of	ge Drive; Lt	20c. Location - City or				
MO	Page nent or ant. If		1 X Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State cemetery, cremato	y Men Gardens	1/21/2012	Timonium,	MD			
3alti	permit. Departr Import: any injt once,		21. Signature of Funeral Sprvide Lic in ee	22. Na	ame and Address of Facili	ty		York Road			
	TD = # 0	Н	23a. Part 1, Enter the disease, or complication		k Towson Fur ne mode of dying, such as			on, MD 21204			
p	hysician/	3 7	shock, or heart failure. List only one cau Immediate Cause (Final disease or condition	se deach line. Acute myoccu	dial In-	tourtinn		Interval Between Onset and De th			
	Medical Examiner		100diting in deating	Due to (or as a consequence of):				10 day			
H		Jer.	Sequentially list conditions, if any, leading to immediate	Congestive +	temet fr	TILURE		10849			
	executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.								
			resulting in death) Last	Due to (or as a consequence of):							
2097	To the Hospital or Attending Physician: The law requires that the death certificate be exwintin 24 hours after death. within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician for the Funeral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burian	Completed by Physician/Medica	d								
Box 68760	ending r use a	an/M	23b. Was decedent pregnant	yes, outcome of pregnancy	ctopic pregnancy		23d. Date of de	· ·			
Bo)	s death the att	ysici	in the past 12 months?		ther (specify)		Month	Day Year			
P.O.	requires that the dea been signed by the a should be detached	y Ph	Part II. Other significant conditions contribu	_	erlying cause given in Part		bacco use contribute to				
ds,	quires en sigr	ted b	PARKINSONS			1 🗆 `	Yes 2 No 3 □ P	robably 4 🗆 Unknown			
Division of Vital Records,	law rec nas ber e 2 sho	nple	Covonary ART	ERY DISEASE		24a. Was a autop		rtopsy findings available completion of cause of			
l Re	sician: The law r certificate has t lirector, page 2 s		25. Was case referred to medical		26 Place of De	1 Yes	2 No 1 ☐ Ye	s 2 No			
Vita	iysicia is certi direct	To Be	examiner? 1 Yes 2 No	tal: 1 Inpatient 2 I ER/Outpatient	Other:	lursing Home 5 Resid	lence 6 Other (Spec	cify)			
of	ing Ph		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	8a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work?		ow injury occurred				
sior	Attend death ctor: / ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	Be. Place of Injury - At home, farm, street,	M 1 Yes 2 factory, office		Street and Number or Ru	ıral Route Number,			
Divi	Hospital or Attending Phys 24 hours after death. Funeral Director: After this ately filled in by the funeral d	1	4 - Homicide determined	building, etc. (Specify)		City or Tow	n, State)				
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check 2 Medical Examiner: C	To the best of my knowledge, death occurrent the basis of examination and/or investigation.	tion, in my opinion, death o	occurred at the time, date a	nd place, and due to the	cause(s) and manner stated.			
:	To the within 2 To the comple	Σ	only one) 3 ☐ Certifying Nurse Pra 29b. Signature and title of certifier	ctitioner: To the best of my knowledge, de	29c. License number		29d. Date signed (Mont				
			* Kathur	DKHALL MD	RES-C	000	Januar	1162012			
			30. Name and address of person who comple			TA OF	> WITTIMA	DE			
	Sta	te	KATHLEEN C. OI 31. Date filed (Month, Day, Year)	82. Registrar's Signature	1	THIC OT !	3 1101 10010				
Pitt	Registr 4H 17 Rev 06-		JAN 1 9 2012	82. Registrar's Signature			<u> </u>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death TA NUCT Physician/ 2012 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Maspital Istourn Handa Northwest 8. Date of Birth (Month, Day, Year) OV • 26,1924 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 1 🗆 M 2 🗗 F 067-24-4732 Director Nov. S. Carolina 87 "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Director Windsor Mill Baltimore 1 Yes 21 No. Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21244 USA Funeral 3237 Southgreen Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Home Care Nurses Aide 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Wilson ၉ Robert Reed alth and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,2\,1\,2\,4\,4$ 19a. Informant's Name/Relationship (Type, Print) Beverly Tisdale-Davis/Daughter Page 1 and 2 siment of Health a tant: If item 27 i 3237 Southgreen Road Windsor Mill, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1-26-12 Cemetery Calverton, New York 1 Xurial 2 Cremation 3 Removal from State 5 Important: It any injury or Calverton National 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris FuneralHome Reisterstown Rd Baltimore. 21215 MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, arrock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{si} ian/ disease or condition resulting in death) newmon Medical as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and that initiated events Due to (or as a consequence of): resulting in death) Last burial-t attending physician Physician/Medical death certificate be P.O. Box 68760 as the k IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Day Month in the past 12 months?

1 Yes 2 No for Pregnant at time of death been signed by the should be detached g Unknown g Unknown or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 21 No. 3 Probably 4 Unknown Division of Vital Records, Be Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed ate has page 2 s 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital Other: 2 1 🗌 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After 1 Natural injury 5 Pendina 1 🗌 Yes Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pertitying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature an D0063322 2012 person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

AM ANDER

9

40

Registrar's Signatu

32

			Pleas						ure All Copie		_	ole.		
		-	State of Maryland / Department of Health and Mental Hygiene 1 - State State Certificate of Death Reg. No. 2									12	\cap	nun
			Registrar 1. Decedent's Name (First, Middle,	Last)			tinoato or a		2. Date of Death 3. Time of Death					_ /
	Physicia Medic	al	Eugenia Tanglis									ear 12	09	PM
0	Examin	er									c. County of Yontgo		y	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth									9. Birthp		e or Foreign
hi	Director	297-50-0465 Usual Residence of Decedent 1 □ M 2 4 F 61							May 2					
	/land f show ed at	tor	10a. State 10b. County			ity, Town or Lo						11		City Limits
	r 28a- notifie	Direc	Maryland Montgo	mery	Ta	akoma P	10f. Zip Code			10g C	itizen of Wh	at Coun		/es 2 ☐ No
	with the s 23a c ust be	Funeral Director	8114 Flower Aven	ue			20912			U.S				
	death ritems inerm		11. Marital Status	Armed Fo	dent Ever in U	.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Orig an, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	0-	14. Race - Black,	America White, e		
036	s after ral", o	Completed by	1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Yes If Yes, Giv Year or Da	е		1 ☐ Yes 2 🛣 No	Specify:			Specify:	Whi	te	
15-0	'2 hour "natu edical	plet	15. Decedent (Specify only highes			(Give	dent's Usual Occup kind of work done	during most	t of working		Kind of Busi		dustry	
212	vithin 7		Elementary/Secondary (0-12)	College (1 5+	-4 or 5+)		o NOT use retired) rch Phys:		Phd	1	rdinar	-	Dept.	
pu	filed v tal Hyg od othe event,	To Be	17. Father's Name (First, Middle, La	st)					er's Name (First, Midd		n Surname)			
Maryland 21215-0036	ould be nd Mer marke matic		Peter Tanglis 19a. Informant's Name/Relationship	o (Type, Print)		19h Maili	na Address (Street		atoula Pan er or Rural Route Num		or Town. Sta	te. Zip C	ode)	
	and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at		Portia Osborne	(Sister)				., Clevela					
nore	age 1 ar ent of He it: If iter y or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Other (Sp.		State	cemetery, crei	osition (Name of matory or other plac Heights	ce) Cem.	Date 1-16-12	1	Location - C $1 \mathrm{eve}1$			
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to		21. Signature of Fineral Service Lice	/_/					Home Rd., Parm	a. 0	н 4413	34		
		Н	23a. Part 1. Enter the disease, or c shock, or heart failure. List on	complications that	caused the dea							1	Approxim Interval E	nate Retween
-	Phylician/		Immediate Cause (Final disease or condition	a a	Se oh	2 2	nock						Onset an	
-	Medical Examiner		resulting in death)	Due to	or as a conse		alcer							
		iner												
	executed an and rial-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	or as a conse		job eucle	UV	C/16 26	2 667		-		
0		I I		d										
68760	artificat ding ph	/Mec	IF FEMALE:	23c. If yes, out	come of pregu	nancy					00.1.0.1	f -1 F		
Box	ed ed	ysician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No g ☐ Unknown	1 🗆 Live	Birth 2 Te	tal death 3	☐ Ectopic pregnand ☐ Other (specify)	cy		-	23d. Date Mont		Day	Year
ls, P.O.	law requires that the nas been signed by tt e 2 should be detach	Completed by Physician/Medica	Part II. Other significant condition Enclishe			esulting in the o	underlying cause gi	ven in Part			use contrib			of death?
Division of Vital Records,	The law rec ate has bee page 2 sho	Somplet							24a. W. au pe 1 🗆 Ye	as an itopsy informed?	pr	ior to co		gs available of cause of
ita	Attending Physician: The sr death. ector; After this certificate h by the funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:			Oth	er.	th (Check only one)					
of V	iding Phys th. After this funeral di	e: To	1 Ves 2 No 27. Manner of Death	28a. Date		ER/Outpatie 28b. Time o injury	f 28c. Injur	y at	ursing Home 5 \square Re 28d. Describ)	
ion	ttendin death. :tor; Aft / the fur	Certificate:	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could n	ation				Yes 2						
Divis	e Hospital or Attend 124 hours after death e Funeral Director; P letely filled in by the f		4 Homicide determin	28e. Place	of Injury - At ing, etc. (Spec		reet, factory, office		28f. Location City or 7	n (Street a Town, Stai		or Rural	Route Nu	mber,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check 2 Medical Ex	aminer: On the ba	sis of examinat	ion and/or inves	stigation, in my opini	on, death o	I place, and due to the ccurred at the time, dat te and place, and due	e and place	ce, and due t	to the ca	use(s) and	manner stated
	To the I		29b. Signature and title of certifier	1 h	MJ	D	29c. Licens	e number	88 Hora	29d. D	ate signed ((Month,	Day, Year)	2012
	20,		30. Name and address of person w		se of death (Ite	em 23a) (Type,	Print) Shoo	ly. G	From H	01 P	- M.E	500	ho.	:16 -
	Sta Registr	te	31. Date filed (Month, Day, Year)	2012 32.F	gistra 's Sigr		back							
DH	MH 17 Rev 06-		31111 4 (enewa.	p. 19	TO THE STATE OF TH							-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Physician/ 1er ranova Januar 30i Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** HOPKINS N/A 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign If Under 24 Hrs Age (In vrs. last birthday) **Funeral** Min Country) 1 □ M 2 😾 F MD Director Feb. 21 1968 214-88-3047 43 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. Count must be notified at Director 1 🗆 Yes 2 😾 No Pasadena Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or 23aFuneral USA 21122 7747 Rockanna Road ral", or items? death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married . Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
Tant: If item 27 is marked other than "natural", or jury or other traumatic event, the Medical Examir jury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore Tank Lines 12 Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Holden Grace Frank Terranova 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7747 Rockanna Road, Pasadena, MD 21122 Vincent D. Herring Date 17 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Jan. 1 Burial 2 XCremation 3 Removal from State Baltimore, Maryland Metro Crematory Inc. 2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility of Funeral Servi 21. Signatur Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. . Enter the disease, shock, or heart failure. List only of Interval Between Onset and Death Immediate Cause (Final SUPA Physician/ : 26 NS B disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last nding physician use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Veal Day Por Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performe death? 2 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical Hospital Other: 1 Yes 2 🔽 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accider injury 5 \square Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Medical Certificate: To Be within 24 hours after death.

To the Funeral Director: After the completely filled in Experimental Director. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 🗆 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signaty anuary 152012 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 40 21287 000 31. Date filed (Month, Day, Year) 32. Registrar's Sign State 9 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 26 per doc g923 1-19-12 vt
State of Maryland 7 Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ INDULL DILLIAM 01 2012 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Rosie Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours 215-28-5633 VA **Director** 30 10 1 XM 2 F 81 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10a, State 10b. County must be notified at Director 1 🗌 Yes 2 🕱 No Parkville Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21234 an "natural", or items 23a Medical Examiner must b Funeral 6607 Collinsdale Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 X Yes 2 □ No Black White, etc. 1 Never Married 2 Married þ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2x No Specify Yes, Give Completed 3 - Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ementary/Secondary (0-12) College (1-4 or 5+) Post Office Supervisor 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Britti Ann Arnett William Bud Tindull 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6607 Collinsdale Road, Parkville, Md 21234 Vanessa Jenkins-Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 1/17/2012 Owings Mills, Md Donation 5 Other (Specify) 22. Name and Address of Facility
March F/H West 21. Signa Funeral Service Licensee Baltimore, Md 21215 4300 Wabash Ave, d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part I. Enter the disease, or complications that caused shock or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as led by the attending get as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 has perform 1 ☐ Yes 2 ☐ No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) assisted

Statence 6 \(\mathbb{X} \) Other (Specify) living examiner? Hospital: Other: 4 Nursing Home 3 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: Natural injury work? 5 Pending s after death. 1 ☐ Yes 2 ☐ No Investigation Accident the 6 Could not be Suicide within 24 hours after des To the Funeral Director completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1/10/2012 D27648 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RD BALTO MDBBI 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 17 Physician/ 2012 1855 Theodore Roosevelt Thomas Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** n/a Baltimore Joseph Richey Hospice Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 212-58-8640 **Director** 1 XM 2 □ F 06/14/1953 Maryland 58 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 😾 Yes 2 🗌 No n/a Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21225 3556 Round Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ģ 1 Never Married 2 Married 1 Yes : 2 X No Maryland 21215-0036 Black 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 Divorced 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4 or 5+) Fitch Janitorial Material Handling Specialist n and Mental Hygier 7 is marked other to 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ Hattie Belle Thomas Henry Edward Thomas Sr. Department of Health and Important: If item 27 is many injury or other traumaone. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1920 Calais Ct. Windsor Mill, MD 21244 Antoinette Thomas- Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 1.23.2012 Hanover, MD 22. Name and Address of Facility

John L. Williams Funeral Directors, 21. Sign Funeral Service 4517 Park Heights Ave Baltimore, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e.g. h.y. e. Approximate Interval Between Immediate Cause (Final disease or condition Physician Medical resulting in death) **Examiner** sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examine page 2 should be detached # r use as the burial-tran that initiated events resulting in death) Last the a endirg physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Theodore 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con tute to the cause of death? þ 3 Probably 4 Unknown 1 🗌 Yes 0 Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed has death? Yes Yes 2 No Thomas 26. Place of Death (Check only one) Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence ျ 2 No ER/Outpatient 3 DOA 1 Inpatient 2 I s after death.

Director; After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending
Investigation
6 Could not be determined 1 Natural 1 Tes 2 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification 30. Na State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY Physician/ TAFFORDG 11:45 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SINAL HOSPITAL OF BALTIMORE BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York Hours Min (Month, Day, Year) 1 X M 2 □ F **Director** 216-24-5192 8 Usual Residence of Decedent 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director r 28a-f sh notified a 1 🗆 Yes 2 🗀 No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code ō must be r 10g. Citizen of What Country? Funeral 5 Pleasant Ridge Dr., Apt. 103 21117 U.S.A. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

12. Yes 2 \(\text{No} \) No 1949—

If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed XX Widowed 4 Divorced Specify: Black 1950 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Operator MTA 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stafford G. Taylor, Sr. Gwendolyn Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrell Taylor (Son) 579 Rich Mar St., Westminster, MD 21158 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place) 4 Donation 5 Other (Specify) Garrison Forest Vets Cem. Owings Mills, MD 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. Signature of Funer John Ice Licenses 11605 Reisterstown Rd., Owings Mills, MD 21117 23a. Party . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ NON-SMALL-CELL-LUNG CARCINOMA disease or condition month Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury The law requires that the death certificate be executed physician and s the burial-tranthat initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Yes 2 L
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed death? 1 Yes 2 No 1 ☐ Yes 2 Z No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: ည 1 🖊 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD RES-000 JANUARY, 17, 2012

DHMH 17 Rev 06-2011

State Registrar

J

HOSPITAL OF BALTIMORE

SINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

JOSHI

L.

BRIJEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month 5 January 11:19 A^M Williams Dorothy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min. Months 250-84-4971 62 Director 1 □ M 2 🗓 F July 2, 1949 South Carolina Usual Residence of Decedent ul Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20772 U.S.A. 10419 Beaver Knoll Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No þ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give SATTican American 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Public School Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever ္ဝ Pearl Murdough Ossie C. Moore t. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark ijury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10419 Beaver Knoll Rd., Upper Marlboro, MD 20772 (Daughter) Valerie Fleming Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or conce. cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sharon Memorial Cem. Ridgeville, SC 1-10-124 Denation 5 Other (Specify) 22. Name and Address of Facility Aiken-Capers Funeral Home 201 East First North St., Sign ture of Juneral Service Li Summerville, SC 29483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 12 9 ☐ Unknown the 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performe this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) 5 Pending Natural M 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

Registrar DHMH 17 Rev 06-201

29b. Signature and title of certifier

1.m 31. Date filed (Month, Day, Year) -

30. Name and add

ane in

IANNW MM

ess of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D357206

11701 Civings Im Road, Fat Waskington, mory had

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Catherine Wheat 01 6:54P Jan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster 8. Date of Birth
(Month, Day, Year)
12-15-1954 Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 😿 F Months Hours 218-58-2838 Director 57 MD Usual Residence of Decedent should be filed within 72 hours and that and Mental Hygiene.
It is marked other than "natural", or items 23a or 28a-f show artic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Carroll MD Westminster 1 Yes 💆 No 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 171 Lincoln Rd. 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Book Production 12 Distributor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlotte Norfolk William Schwartztrauber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra William Wheat-husband 171 Lincoln Rd., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) South Carroll Crem 1-17-12 Sykesville, MD 21. Signature / uneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD 21157 womas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Day to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant
in the past 12 months?
1 Yes 2 No 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death Pregnant at time of death Month Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the pause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy perform certificate 1 Yes 2 No Yes 2 No To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Mann of Death To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or 29d Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Flavio Kruter
31. Date filed (Month, Day, Year)

32. Registrar's Signature

555 S. Center St., Westminster, MD 21157

		Please Type AME State	or Print in ND_ITEM#1	Black I	ndelible In	k. Ensure A	All Copies	Are Legi	ible.			
		State Registrar	State Registrar (Reg. No. 2012 01047				
Physicia Medic		1. Decedent's Name (First, Middle, Last) Lurline			Wizzart		2. Date of Death Month	nth Day Year				
Examin		4a. Facility Name (if not institution, give street and Gilchirst Hospice	number)			r Location of Death		4c. County				
Funeral Director		5. Social Security Number 6. Sex 1 \(\text{ 1 \subset M 2 \text{ 1 \subset M 2 \text{ 2}} \)	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)		Birthplace (State or Foreign Country)				
	ı.	Usual Residence of Decedent 10a, State 10b, County	10c Cit	Yrs. y, Town or Lo	ncation		10 11	27	Jamaica 10d. Inside City Limits	_		
Marylar 28a-f sl otified	irecto	MD Raltimore		Balt:	Owings M	ills			1 Yes 2 X No)		
death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	9773 Groffs Mill Dr. A	pt 108		10f. Zip Code	21117 1215	. 10	$_{ m U}$. Citizen of W	/hat Country? • S • A •	0		
	þ	1 Never Married 2 Married Armed 1 Never Married 2 If Yes,	Decedent Ever in U.S d Forces? fes 2 X No Give or Dates.		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc. Black			
Z1Z15-UU36 within 72 hour after giene. er than "natural", o , the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade comple	ted)	(Give	dent's Usual Occup kind of work done of OO NOT use retired)	during most of work	ing 1	6b. Kind of Bu	siness/Industry			
land 212 be fill d within ental Hygiene. ked other tha ic event, the N	Be Cor	6th grade na	e (1-4 or 5+) 3		ld Care	Provide			more City			
Iryland 2121 build be filed within 7: d Mental Hygiene. marked other than matic event, the Me	To B	17. Father's Name (First, Middle, Last) Charlie Shaw					e (First, Middle, Ma shia Re)			
d 2 should alth and M 27 is mar er traumati		19a. Informant's Name/Relationship (Type, Print) Ophelia A. Brown-Da	aughter		ng Address (Street) - Mable - Algiers		al Route Number, C #2017 11stown			0		
baltimore, Maryla permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic.		20a. Method of Disposition 1 ※ Burial 2 □ Cremation 3 □ Removal f 4 □ Donation 5 □ Other (Specify)		lace of Disp	osition (Name of matory or other plac	ce)	Date 2	0c. Location -	City or Town, State			
balt permit. Departr Imports any inju		21 Signature of Funeral Service Licensee	i Mad	1 2 8	2. Name and Addre	ss of Facility I West	Baltim	ore. I	Md 21215			
∼Physician/		28a. Par 1. Enter the disease, or complications the slock, or heart failure. List only one cause of Immediate Cause (Final	nat caused the deat n each line.						Approximate Interval Between Onset and Death			
Medical Examiner		disease or condition resulting in death) Due	to (or as a consequ	uence of):	Calla	warrie	3 back	1	7 Cours	_		
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):								_		
executed an and rial-transi	Examiner	Cause (Disease or injury that initiated events c	to (or as a consequ	ence of):				_				
	dical	d								_		
or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the bu		in the past 12 months?	outcome of pregna ive Birth 2 Feta regnant at time of c Inknown	I death 3	Ectopic pregnand Other (specify)	су		23d. Date Mon	e of delivery ith Day Year			
requires that the been signed by should be deta	≥	Part II. Other significant conditions contributing	to death but not res	ulting in the	underlying cause giv	ven in Part I.			bute to the cause of death?			
The law requires ate has been signage 2 should t	Completed						24a. Was an autopsy perform 1 Yes 2	ed? p	Vere autopsy findings available rior to completion of cause of eath?			
Physician: The this certificate I ral director, pag	Re	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ ₩0 Hospital:			Oth	ace of Death (Chec	k only one)			_		
ding Phys h. After this funeral d	<u>:</u>	27. Manner of Death 28a. D	Inpatient 2 ate of injury fonth, Day, Year)	28b. Time o injury	nt 3 🗆 DOA	4 ∐ Nursing Hoy y at	ome 5 Residen 28d. Describe how			_		
Attending r death. ector: Afte	Certificate:	2 Accident Investigation	ace of Injury - At ho		M 1 🗆	Yes 2 □ No	28f. Location (Stre	n (Street and Number or Rural Route Number,				
oital or urs afte ral Dire		4 - Horricide determined bu	ilding, etc. (Specify)		State)						
To the Hospital or Attendition (1) the Hospital or Attendition (1) the Funeral Director: At completely filled in by the fi	Medical	29a. Certifier (Check (Check only one) 3 Certifying Nurse Practitio	basis of examination	and/or inves	tigation, in my opinio	on, death occurred a	the time, date and	place, and due	to the cause(s) and manner state	d.		
To the with To the come		29b. Signature and fitle of certifier	MA		29c. License	e number	29	d. Date signed	(Month, Day, Year)			
2		30. Name and address of person who completed of	ause of death (Item	23a) (Type, I	Print)	Cor Cin	ITS 410	3 C D	LALTIMORE M	1		
State Registra			2. Registrar's Signat				×112 Ct16	2	THE TOTAL !	V		
HMH 17 Rev 06-20		JAN 1 9 2012 12	how ,	7. 16	eckel							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year MILDRED AM 0440 ANUARY 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1513 Delvale Avenue Dundalk Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 215-24-5481 Director 83 February 5, 1928 | Maryland Usual Residence of Decedent with the Maryland or 28a-f show 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits notified at 1 ☐ Yes 2 ▼No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **⊐ust be** 23a 1513 Delvale Avenue 21222 USA r death Funeral items : 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ann of Health and Mental Hygiene. ant It Item 27 Is marked other than "natural", or ite muy or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married Married 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No ģ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Wanner ပ Verge Moreland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Wilson Husband 1513 Delvale Avenue, Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January permit. Pages Department of I Important: If its any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Mary Cem. Dundalk,Maryland 19, 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BUDDER CANCER disease or condition resulting in death) MONTIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? been si 1 □ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 2 No 1∐ Yes Attending Physiclan; completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; within 24 hours after death.

To the Funeral Director; After 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospitai

P.O. Box 68760, Division or Vital Records,

6 V

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

JENNIFER HAYASHI

29c. License number 1062032

BAYVIEW CIRCLE

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Nome and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

JANUARY 17 2012

BALTO, MD 21224

5505 HOPKINS 31. Date filed (Month, Day, Year) JAN 1 9 2012

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Gertrude C. Wannall 2:30a January Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Carrol1 Sykesville Fairhaven 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 DC If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours 1 🗆 M 2 😾 F 93 Yrs. 579-01-5252 July 4 1918 **Director** Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director Sykesville MD Carrol1 1 Tyes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21784 7200 Third Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white Completed 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) 2 should be filed within 72 in the and Mental Hygiene.
77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Clara Agnes Barnes Ralph Freeman Crane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10313 Cavey Lane, Woodstock, MD 21163 Anne W. Hart (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 XCremation 3 Removal from State All County Cremation | 1-19-12 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licenses Dage Hought Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition troke Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** rebrousen Sequentially list conditions, if any tracing to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) physician and the bunal-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the bunal Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day in the past 12 months?
1 Yes 2 No Pregnant at time of death the Unknown 9 Unknown P.O. I þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed be should be deta Certificate: To Be Completed by Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has the lirector, page 2 s performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at injury work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending Accident
Suicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director:,
completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 18 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dersbur 1645 Libert illiam lan 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 John Alexander Witzen January 4:13 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Hours (Month, Day, Year) **Director** 216-20-6327 1X M 2 □ F 85 Nov. 25, 1926 Maryland show 10a. State the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD 1 Yes 2X No Baltimore Towson 10e, Street and Numbe 10f. Zip Code o 10g. Citizen of What Country? must be Funeral 23a 615 Chestnut Avenue 21204 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired, Elementary/Secondary (0-12) College (1-4 or 5+) Vice President USF&G Insurance Co. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည John Alexander Witzen Sr. Lillian Kenly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health attem 27 i Mae S. Witzen wife 615 Chestnut Avenue #485; Towson, MD 21204 any injury or other 20a. Method of Disposition
1 ★ Burial 2 ← Premation 3 ← Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I cemetery, crematory or other place, Other (Specify) 4 Donation 5 Most Holy <u>Redeemer</u> 1/19/2012 Baltimore, MD Signature of Fun 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication Approximate shock, or heart failure. List only one ca Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death ed by the a detached f 1 Yes 2 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has la director, page 2 s autopsy performe 1 ☐ Yes 2 X No 1 Yes 2 No director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 🗶 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 24 hours after death.
Funeral Director: After this etely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? Accident
Suicide Investigation 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier within 24 hou

To the Fune

completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ANUARY

JOHN WITZEN

Registrar DHMH 17 Rev 06-2011

State

(Check

30. Name and a

29b. Signature and title

JACKIE

JONES,

CRNP

2300 DULANEY VALLEY RD.

erson who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. Sity, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospita Baltimore Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth If Under 24 Hrs **Funeral** Hours (Month, Day, Year) 219-59-8352 Director 1 🗆 M 2 🗶 F 49 10-13-1962 China or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2X No MD Elkridge Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or "natural", or items 23a o Funeral 7710 Spreading Oak Lane 21075 China 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married by 2 XNo Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3 Widowed 4 Divorced Asian Completed Year or Dates er than "natur , the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Construction Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ (Unavailable) (unavailable) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other traumone. Ellie Miao - daughter 7710 Spreading Oak Lane, Elkridge, MD 21075 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 01- 18-2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signat MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Y JENINGKY ZA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page performed? Yes 2 X No 2 No certificate 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 X No မ 1 🕽 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 24 hours after death.
Funeral Director: After etely filled in by the funer (Month, Day, Year) injury 1 X Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor

To the Fune

completely f 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) d title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature a 29c. License number

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of

person who completed cause of death (tem 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

SINA! HOSPITAL

32. Registrar's Signature

BALTIMORE MU 21215

OF BALTIMORE, LLDI W. BELVEDERE AVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BANAVAL

9 2012

ASHTAMI

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Kiruara Lindeberg Pereira de Araujo 1:30M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs, last birthday) 8. Date of Birth **Funeral** Hours Min Brazil 6/24/1947 Director 1 X M 2 □ F 458-49-4348 64 Yrs Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No MD <u>Washington</u> Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11211 JFK Drive, #214 21742 U.S.A. Page 1 and 2 should be filed within 72 hours after death \u00fanto f Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes 2 KNo Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Spiritual <u>Pastor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Demerval Pereira de Araujo Nelzira Diniz D'Armas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2662 Paddington Rd., Ft. Collins, CO 80525 Kennyberg Araujo / Son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of I Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/10/2012 Smithsburg, Maryland Smithsburg Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel MD 21742 Hagerstown, 1601 Pennsylvania Ave., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ Hypoxemi 1 COTOVL disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Se condary Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of ROVECII and burial-tra Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
? Euneral Director: After this certificate has been signed by the attending physician AIDS P.O. Box 68760 the as IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has the page 2 s autopsy performed death? 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner Death Certificate: 28a. Date of injury 28b Time of 28c, Injury at work? 28d. Describe how injury occurred (Month, Day, Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number FILLIO 0061 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NERS Meriros PIANCISCO 2. Registrar's Signature State Registrar

S DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Isabel Marie Amerson 2012 Ear 18 Jänuary 6:50 P М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Egle Nursing and Rehab Center Allegany Lonaconing Social Security Number 8. Date of Birth (Month, Day,) Jan. 31 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 234-58-1527 1 □ M 2 🔀 F Hours 92 South Carolina Director 1919 Usual Residence of Decedent f show mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland nartment of Health and Mental Hygiene. Sortant: If item 27 is marked other than "natural", or items 23a or 28a-f shor injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Westernport 1 🗆 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20413 Lower Georges Creek Road 21562 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 I No Specify: white 3 X Widowed 4 ☐ Divorced Completed Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical 12 Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Kennedy Atkinson Banie Amerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori Beeman/granddaughter 20413 Lower Georges Creek RD, Westernport MD 21562 20a, Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important; If ite Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Cumberland Crematory | 01/14/2012 4 Donation 5 Other (Specify) Cumberland Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home апу 111 Church St. Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician CEREBRO VASCULAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immedicause. Enter Underlying Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year ☐ Pregnant ☐ Unknown detached within 24 hours after death.

To the Funeral Director: After this certificate has been signed by is completed filled in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERY 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown DEMENTI 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗌 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? Investigation 2 🗌 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🔲 within 2 To the I only one 29b. Signature and title of certifier 29c. License number 26 JANUARY 11 Halm 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harjit Sidhu, 925 Bishop Walsh Road, Cumberland, MD 21502 31. Date filed (Month, Day, Yea JAN 1 1 2012 State backer

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year Michael . Butts January 8:33 A M Scott Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1530 Broadfording Road Washington Hagerstown 5. Social Security Number 8. Date of Birth (Month, Day, Year) Apr. 16, 1963 **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Linder 24 Hrs 9. Birthplace (State or Foreign 1 X M 2 □ F Days Hours Min. West Virginia Director 236-08-5192 48 Usual Residence of Decedent show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked of other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified as 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country's Funeral 1530 Broadfording Road 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Horseman Self-Emplyed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Boyd В. Butts Janet Dove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lititia G. Butts / daughter 1530 Broadfording Road Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 01-04-2012 Frederick, Maryland 22. Name and Address of Facility
Bast-Stauffer Funeral Home,
COC Old National Pike Boonsboro, MD 21713 21. Signa are of Funeral Service lices 7606 Old National Pike Boonsboro, MD the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leart failure. List only one cause of each time. 23a, Part 1, Ente Approximate shock, or Interval Retween Immediate Pause (Final disease or condition resulting in death) Onset and Death Physician ance Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a 9 ☐ Unknown ed by the a detached i 9 Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed certificate 2 🗆 No 1 Yes Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year)

JW-5

DHMH 17 Rev 7/2009

Registrar

address of person who completed cause of death (Item 23a) (Type, Print)

14

gistrar's Signature

LARS

1+

Date filed (Month)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Boal 6:30 P Dolores Ann January 7, 2012^{ear} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frostburg 4c. County of Death
Allegany **Examiner** Frostburg Nursing and Rehab Center If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 5. Social Security Numbe 217–30–1371 8. Date of Birth Days Hours June 29 78 °1933 Maryland Director 1 M 2 X F 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Garrett notified MD Bloomington 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 21523 0 10g. Citizen of What Country? ms 23a or must be Funeral Hamill 157 Ave. United States permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hyglene. Important: I flem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc.
White þ 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) School System Elementary/Secondary (0-12) College (1-4 or 5+) Instructional Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Warnick Marion Bever 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12905 Old School Road, Mt. Savage, Maryland 21545 19a. Informant's Name/Relationship (Type, Print)
Autumn Mancuso/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 01/10/2012 Bloomington Maryland Bloomington Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home 21562 111 Church St, Westernport, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ALZHEIMER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) for use as the burial-tran and Due to (or as a consequence of) attending physiciar Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Name Practitioner: To the basis of my included and control of the cause(s) and manner as stated. (Check within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) Itseller D26907

DHMH 17 Rev 06-2011

State Registrar

Dr. Harjit Sidhu, 925 Bishop Walsh Road, Cumberland MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JANUARY 09

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:30 A M 2012 Jänüary Linda Lee Bradley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hancock 14413 Heavenly Acres Ridge 8. Date of Birth (Month, Day, Year)
Aug. 25,1946 9. Birthplace (State or Foreign Country)
Mary Land Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours 219-44-4377 Director 65 1 □ M 2 💢 F permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hancock 1 🗆 Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? Funeral 21750 U.S.A. 14413 Heavenly Acres Ridge 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) 12College (1-4 or 5+) Correctional Officer State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hilda Lambert Bruce S. Bingaman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14413 Heavenly Acres Ridge Hancock, MD 21750 Ralph C. Bradley, Jr.-husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park | 1-11-2012 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Sunature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other 23e. Did tobacco use contribute to the cause of death? Completed by MU 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 -110 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 62 ed cause of death (Item 23a) (Type, Print) LASS 113 11117 31. Date filed (Moi egistrar's Signatur State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Rea. No 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month Barbara Ruth Bennington January 20124:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince Georges Laurel 5. Social Security Numbe . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 TXF Hours 09/04/1928 **Director** 213-22-9750 Maryland 83 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No Maryland Prince Georges Beltsville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4212 Howard Road 20705 items within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ō 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 XWidowed 4 Divorced Specify. Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 H.S. Grad Clerical work Various businesses Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ pe Edwin Garey Satterfield Ethe1 Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh. Department of Health ar Important: If item 27 is A. Garey Bennington/son Beltsville, Maryland 4212 Howard Rd., Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State njury or 4 Donation 5 Other (Specify) Veterans Cemetery 01/05/2012 | Hurlock, Maryland Signature of Funeral Service 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Congestive heart failure Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 Yes 2 No Yes 2 WNo 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) 2 1 No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Matural (Month, Day, Year) 5 Pending work 1 Tyes 2 No Accident Investigation М within 24 hours after deatl Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature License number 29d, Date signed (Month, Day, Year) 10063580 . 2.2012 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Lawel

7300

Registrar's Signature

a laub

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Bryan Keith Christopher January 0848 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 919 Kirk Road Elkton Ceci1 8. Date of Birth (Month, Day, Year) **Funeral** Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Days Hours 220-86-7942 **Director** 1 X M 2 □ F OCT 27, 46 1965 Delaware Usual Residence of Decedent 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 919 Kirk Road 21921 United States 12. Was Decedent Everings. Armed Forces? 1983 to 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ge 1 and 2 should be filed within 72 hours after deat 11 of Health and Mental Hygene. I if item 27 is marked other than "natural", or iter or other traumatic event, the Medical Examiner. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1986 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 life. DO NOT use retired) College (1-4 or 5+) Plumber Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Christopher Eleanore Kowalski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Jones/Power of Attorney 105 Andora Drive, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot I cemetery crematory or other place)
Immaculate
Conception Cemetery X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 14. 2012 Cherry Hill, MD 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 22. Name and Address of Facility 103 W. Stockton Street, Elkton, MD 21921 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Neumoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **X**Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause completely (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of MD D0062190 SHAHNAWAZ KHANMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HWY, SUITE A AUGUSTINE HERMAN , CHESAPEAKE CITY

Registrar

32. Registrar's Signatura

		For State Registrar	Please			Black Ir nd / Depa <i>Cer</i>		t of He	ealth		-		egible	2 01	1061
Physicia Medic		1. Decedent's Name (First	, Middle, Last) Robert	Clar	k						2. Date of De Month		201	3. Time (оf Death_ 305 м
Examin	-	4a. Facility Name (if not in: WM. Regiona	4b. City, Town, or Location of Death Cumberland					4c. County of Death Allegany							
Funeral Director		5. Social Security Number 217–88–4699 Usual Residence of Dec	If Under Months	If Under 1 Year If Under 24 Hrs. 8. Date of Bir Months Days Hours Min. (Month. Da June 25					9. Birthplace (State or Forei Country) 1961 West Virginia						
Maryland 28a-f show otified at	Funeral Director	10a. State 10b. A	_{County} 1 legan y			ity, Town or Lo Barton	cation							10d. Inside (City Limits
s 23a or	neral D	10e. Street and Number 18719 Temp	erance	Row			10f. Zip Code 21521						n of What C ted S		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ □	X Married	2. Was Deced Armed For 1 Yes If Yes, Give Year or Dat	ces? 2 🔀 No			fy Cuban	, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		Black, Whi	erican Indian, te, etc. hite	
within 72 hor gjene. ner than "nat t, the Medi ca	Completed		Decedent's Edu nly highest grad (0-12)		4 or 5+)	life. D	lent's Usua kind of wor O NOT use I er-o r	done du retired)	ing mos	t of worki	ing	16b. Kind Co	of Business al	s/Industry	
d be filed Jental Hy arked oth	To Be	17. Father's Name (First, M Richard		k						er's Nam Norm	e (First, Middle, la Brac	Maiden Sur lley	name)		_
nd 2 should saith and N n 27 is ma		19a. Informant's Name/Robin Clark		e, Print)		19b. Mailir 18719	g Address Temp	(Street ar	nd Numbe	er or Rura	Barton,	nr, City or Too Mary	vn, State, Z land	ip Code) 21521	
Page 1 arment of Ha ant: If iter ury or oth		20a. Method of Dispositio 1 Surial 2 ☐ Cre 4 ☐ Donation 5 ☐	mation 3 🗆 F	temoval from S	01-1-	Place of Dispo cemetery, cren View	natory or or	her nlace) 0	1/12	2/2012			r Town, State ryland	
permit. Departimport any inj		21. Signature of Funeral S	Service Licenses	Be	7		Name and				oal Fur ternpoi			d 21562	2
Physician/ Medical Examiner		23a. Part 1. Enter the dis shock, or heart failul Immediate Cause (Final disease or condition resulting in death)	ease, or compli re. List only one	cause on eac	aused the dea th line. C C (2 or as a conse	((er the mode			cardiac o	or respiratory ar	rest,		Approxim Interval Be Onset and	etween d Death
be executed siclan and burial-transit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ns, b		or as a conse										
cate be or physicials the burners	edical		L.												
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregn in the past 12 month: 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	carre 1		Birth 2 Fe ant at time of	tal death 3	Ectopic p Other (sp					230	d. Date of de Month	elivery Day	Year
equires that the sen signed by tould be detail	۵	Part II. Other significant	conditions con	tributing to de	eath but not re	esulting in the u	nderlying o	ause give	en in Part	1.				to the cause of	_
The law reate has be page 2 sh	Completed										24a. Was auto perfe 1 \(\subseteq \text{Yes}		prior to death?	utopsy findings completion of es 2 \(\sime\) No	s available f cause of
sician: certific irector,	Be	25. Was case referred to rexaminer?		ospital:				Other		`	k only one)				
nding Physath. r: After this ne funeral d	Certificate: To	27. Manner of Death 1. Natural 5 2 Accident	28b. Time of injury	ent 3 🗆 DOA 4 🗀 Nursing Home 5 🗀 Residence 6 🗀 Other (Specify					cify)						
tal or Atters after safter de al Directo ed in by the		3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined		of Injury - At h g, etc. (Speci		eet, factory, office 28f. Location					(Street and Number or Rural Route Number, own, State)			nber,
ne Hospir in 24 hour ne Funera pletely fill	Medical	(Check 2 DM	ertifying Physic edical Examine ertifying Nurse	er: On the basi	s of examinati	on and/or inves	tigation, in r	ny opinion	, death o	ccurred at	t the time, date	and place, ar	d due to the	e cause(s) and n	nanner stated.
To t with To tl		29b. Signature and title of	certifier	!hi	VC	/	29c.	License i	number 76 (6		_	_	th, Day, Year)	/
	4	30. Name and address of Dr. Vikran	person who co naditya	npleted cause Poonai	e of death (Ite	m 23a) (Type, F Seton 1	Print) Orive	, Cun	mber]	land	MD 215	02			
Stat Registra		31. Date filed (Month, Day,	9 2012	\$2. Re	gistrar's Sign	ature	w								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ralph Samuel Crowe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Western MD Regional Medical Center Cumberland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral If Under Year If Under 24 Hrs. Days Director 1 X M 2 D F 60 March 07, 1951 Maryland 215-58-6454 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits at 10c. City, Town or Location Director notified 1 Yes 2 No Cresaptown Maryland Allegany 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 14101 Winchester Rd SW must be 23a Funeral with U.S.A 21502or items death "natural", or item edical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force þ 1 Never Married 2 Married 72 hours after 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced Completed White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **Brick Yard** Laborer and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jeanette Winebrenner Samuel Crowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 16107 Mount Savage Rd NW Mount Savage Maryland 21545-JoAnn Whetstone sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🖍 Cremation 3 ☐ Removal from State Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory Jamuary 04, 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician myotardio disease or condition Medical resulting in death) Due to (or as a cons quence of) **Examiner** ovenbuy if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events anter Examine Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? ō Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate I 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural Accident injury 5 Pending 124 hours after deam.

1e Funeral Director Affiled n by the fi Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID 1/3/12 072514 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nds 12500 Cumberland MO Willowbook Liu Kellu 31. Date filed (Month) 32. Registrar's Signature

State

Registrar

C. Carlo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 8, 2012 Year Helen Ruth Chapman 6:26 А м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Broadmore Senior Living Center Hagerstown Washington Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 M 2 STF Min. 10/31/1920 Director 220-09-7130 91 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1175 Professional Court 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 ₩ Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1**2** <u>Homemaker</u> **Home** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of permit. Page 1 and 2 should be flit Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve Harry Roy Cromer Christiana Elizabeth Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas V. Chapman / Son 115 Sunbrook Lane, Hagerstown, MD 21742 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Cemetery Jan. 11.2012 Williamsport, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 3, 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ 5.00 Onset and Death disease or condition resulting in death) Medical Due to or as consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed the bunal-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as IF FFMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy 3 🗌 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No • Hospital or Attending Physician: 7 24 hours after death. • Funeral Director: After this certifice Be 25. Was case referred to medical examiner? of Vital filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASS, sted by 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Division 2 Accident
3 Suicide
4 Homicide Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my line who as a state of the cause of due to the cause of the To the Within 2 imed at the time, data and plane, and due to the cause(s) and manner as etated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 JW-3 21740 ARID MUNITED

State Registrar 31. Date filed (Month,

12-00038 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Shirley Weiner Caliman 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 2, 2012 **Medical Examiner** Caliman Shirley W. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Howard 6246 Wild Swan Way Columbia 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Hours Director Apr 12, 1928 83 122-20-8877 1 M 2 X F Yrs Usual Residence of Decedent 10a State 10c. City. Town or Location 10b County or 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine.
Important: If item 27 is marked other than "matural", or items 23a or 28a-5 about injury or other traumafte event, the Melical Examiner must be notified at once. MD Howard Columbia Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21045 6246 Wild Swan Way Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 X No 3 Widowed 4 Divorced Yes, Give Year Specify: White 1 Yes 2 No specify: 5 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 Own Home Homemaker 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Μ. Sallv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) ۵ 6412 Warm Sunshine Path Clarksville, MD 21029 Stahl/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place Woodbridge Township, 1 Burial 2 Cremation 3 K Removal from State Pk 1/6/2012 Clover Leaf Memorial 4 Donation 5 Other Specify 22. Name and Address of Facility Harry H. Witzke's Family FH, 21. Signature of Funeral Service Licenses homa Columbia Pike Ellicott City 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. /Medical a. Multiple Injuries complicating Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and or use as the burial - trans Physician/Medical UNPENDED AMENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 1 Yes 2 V No 9 Unknown for Unknown the detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 V Unknown Renal disease; Osteoporosis Completed After this certificate has been sfuneral director, page 2 should 24a Was an 24b. Were autopsy findings available autopsy performed? ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 D0A Nursing Home 5 Residence 6 ✔ Other: Scene 1 Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Subject fell 1 Natural FOUND: Yes 2 V No 5 Pending

Division of Vital Records, P.O. Box 68760. within 24 hours after death. To the Funeral Director:

2 Accident	Investigation	Jan 2, 2012	0/33 nrs			
3 Suicide 6	Could not be	28e. Place of Injury -	At home, farm, street, facto	ory, office building, etc.	28f. Location (Street and or Town, State)	d Number or Rural Route Number, City
4 Homicide	determined	(Specify) Single	amily Home		6246 Wild Swan Way	, Columbia, MD
				the time, date and place, an		
one) 2 Medic	al Examiner:On and	the basis of examinati d manner stated,	on and/or investigation, in	my opinion, death occurred		
29b. Signature and title of	f certifier			29c. License number	29d. Da	ate signed (Month, Day, Year)
Quel	2			O.C.M.E.	Janu	ary 3, 2012
30 Name and address of	person who com	pleted cause of death	Item 23a)			

Barks

900 W. Baltimore Street, Baltimore, MD 21223

DOME

3. Time of Death

0742 hrs

10d. Inside City Limits

1 Yes 2 No

ŊJ

Approximate Interval

Between Onset and

Death

Year

Dav

1 🗸 Yes

prior to completion of cause of

Foreign

Country)

12

State Registrar

Medical

Ana Rubio MD 31. Date filed (Month

2012

5

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0215 M Daron 2012 Kenneth Gene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 380-76-0321 Director 1 ★ M 2 □ F 51 Yrs May 10, 1960 Fort Knox, KY Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location must be notified at Director 1 🗌 Yes 2 🔀 No Cascade MD Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21719 US 775 Catoctin Circle Apt. 1 ral", or items? death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify white 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene.
item 27 is marked other than
other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) restaurant chef Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mildred E. Burrows Dale A. Daron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17268 226 W. Second St. Waynesboro, PA Kristopher Daron Department of Healt Important: if item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Jan. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Waynesboro, PA Cumberland Valley Crematorium 4 Donation 5 Other (Specify) Grove-Bowersox Funeral Home, Inc. 21. Signature of Fun eral Service Lice Fe 22. Name and Address of Facility Waynesboro, 50 s. Broad St. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ makinant disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cardiom Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consecution of Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ed by the attending p detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown is certificate has been signed by t director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ျ 1 Yes 2 X 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After 1 Natural injury 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f (Check 3 the only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tit 0056379 12 de rson who completed cause of death (Item 23a) (Type, Print) Name and address of 5530 Wisc Aue #700 400 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible /pk/Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 9:07 PM Physician/ Kathleen M. Doyle-Parker 2012 January Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5°2<u>"i'9</u>955 **Funeral** Days (Month, Day, Year) Hours 70 Director 1 🗆 M 2 🔀 F Washington, DC March 12, 1941 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State must be notified at Director 1 X Yes 2 ☐ No Greenbelt Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20770 items 23a 22 Ridge Road, #314 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Examiner Armed Forces 1 ☐ Yes 2 🔀 No If Yes, Give ō δ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3

Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Marche Florist other than Elementary/Secondary (0-12) College (1-4 or 5+) Customer Service Representative Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental Kay Kernan William Wells Woods i and 2 shour. of Health and M 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tra-3828 Mulberry Point Court, Dumfries, VA 22025 Judith W. Anderson / Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Page 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/4/2012 Alexandria, Virginia Metropolitan Crematory 22. Name and Address of Facility Signature of Funeral Service Licensee 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. RAY Rogers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Incol Cours heoit Physician/ 05 disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day in the past 12 months? Pregnant at time of death Yes 2 No detached 9 | Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? s been signer should be c 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ne umonica Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 death? 1 ☐ Yes 2 ☐ No 2 X No nImonory 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA 2 🗙 No ၉ this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death. e Funeral Director: A bletely filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, details does not due to the cause(s) and manner as stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the F

complet only one) 29d Date signed (Month, Day, Year, 29b. Signature and title of certifie 2012 02 Con 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 2000 Medical Parkway, Annapolis, MD 21401 Robert T. Peterson, 32. Registra State JAN 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 01^{Month} Day Physician/ Donham Kathryn Jean 2012 2:25 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Garrett Co. Memorial Hospital 0akland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Min. 02 Month, Day, Hours 1 □ M 2 🗷 91 PA **Director** 167-14-7937 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County the Medical Examiner must be notified at Director Mt. Lake Park 1 Yes 2 No MD Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö Funeral items 23a USA 21550 216 F. Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗷 No Black White, etc. 6 1 Never Married 2 Married þ Yes 3altimore, Maryland 21215-0036 after 1 ☐ Yes 2 M No Specify: Specify. If Yes. Give White "natural", Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done of life, DO NOT use retired) during most of working 72 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) medical 12 seamstress other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Pearl Hummel Webster F. Dewalt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or water 835 E High St, Oakland, MD 21550 Randy Donham-son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Garrett Co. Memorial Gardens 1 A Burial 2 Cremation 3 Removal from State Oakland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home PA Funeral Service Lice 21 N 2nd st, Oakland, MD 21550 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) 4 GOV J **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of) attending physician for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u in the past 12 months? Day Month Year Other (specify) Pregnant at time of death g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 🗆 Yes 2 🗆 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Mann eath 28c. Injury at work? iniury 5 Pending Natural Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 012 333

Registrar

DHMH 17 Rev 7/2009

State

Thomas G. Johnson, M.D., 311 North Fourth St, Suite II, Oakland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

31. Date filed (Month, Day, Year) **JAN - 5** 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 08:00 PM January 02, 2012 Earl S. Davis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Egle Nursing & Rehabilitation Center Lonaconing 9. Birthplace (State or Foreign Country) **Maryland** 8. Date of Birth (Month, Day, Year) September 07, 1920 If Under 1 Year If Under 24 Hrs . Age (In vrs. last birthday) **Funeral** Days Months Director 91 212-18-1494 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 ☐ No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10909 Welsh Hill Road Funeral U.S.A 21532- Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced WWI White Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natur ury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electric Utility Company Clerical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ **Ruth Lewis** John Samuel Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21532-10909 Welsh Hill Frostburg Ida M. Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Frostburg Frostburg Memorial Park January 06, 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STRUCTIVE Flysician/ CHRONIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Descriptor ов а сонваршелов М Cause (Disease or linjury the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Year Month Dav 5 Other (specify) Pregnant at time of death signed by the aid be detached for 1 ☐ res ∠ ☐ 9 ☐ Unknown To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' 1 ☐ Yes 2 ☐ No certificate Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural iniury work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

TAR 31. Date ii

4

who completed cause of death (Item 23a) (Type, Print

Registrar's Signature

Registrar

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01 Physician/ 2012 03 1:33 A M James R. Dancy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton Union Hospital 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Min. Days (Month, Day, Year) 10/26/1936 1 🔀 M 2 🗆 F Hours Director 282-30-5474 Usual Residence of Decedent show ould be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 XNo MD Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16 Morning Glory Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates. or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Supervisor Polymers Dept. Dupont Be . Page 1 and 2 should be filed trnent of Health and Mental Hy tant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richard M. Dancy Ella G. Hinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monnie S. Shrewsbury - wife 16 Morning Glory Drive, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Head of Christiana Cem. 1/5/12 Newark, DE Signal of Funeral Service Insee 22. Name and Address of Facility R.T. Foard Funeral Home, PA 259 E. Main Street, Elkton, MD 21921 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Wears Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ng physician and as the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? this certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Funeral Director: After Natural work? 5 Pending 1 Yes 2 No Investigation ☐ Accident completed filled in by the 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of sifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

TIVA

back

1.4.2012

Election MD 21921.

Each Lew 5 Mid

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Grace Eleanor Edwards 7:15 PM 2012 lo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Village Hagerstown Provenwood utheran If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Months Hours 1 □ M 2 V F 90 Director Feb.21,1921 New Jersey 156-01-3206 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at Md. 1 ☐ Yes 2 ☐ YNo Director Washington Smi thsburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22927 Stevenson Rd. 21783 U.S.A Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natu any Injury or other traumatic event, inc. the first 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Earle Ising Minnie Bays 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas M. Edwards (Son) 22927 Stevenson Rd. Smithsburg, Md. 21783 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 10, Smithsburg, Md. Smithsburg Cemetery
22. Name and Address of Facility 2012 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Par1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MIMS Due to (or as a consequence of): Heart-/Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760. After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 (No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To | 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manher of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: / filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1-9-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

State

31. Date filed (Month, Day,

JAN 1 9 2012

368 n

1.+12

32. Registrar's Signature

Stut- i-terestern PPD

or Baltimore, Maryland 21215-0036 "natural", filed within 72 al Hygiene. should be file h and Mental H is marked o

attending physician Box 68760 P.O. signed by Records, this certificate has Division of Vital after death.

for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2012 Lureta Elbin Velma 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Allegany Cumberland If Under 1 Year | If Under 24 Hrs 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min (Month, Day, Year) 08/17/1923 177-32-8344 **Director** 88 1 🗆 M 2 🗓 F Pennsylvania 28a-f show 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Allegany Cumberland 1 🗌 Yes 2 💢 No ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 12014 Iris Avenue items 23a Funeral 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Completed 3 🕅 Widowed 4 □ Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) School Bus Aid Public Schools traumatic event. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Emory Northcraft Grayson Olive Mae Bennett Department of Health and Important: If item 27 is n. any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marvin Lee Elbin / Son 11904 Iris Avenue, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 01/09/2012 Mt. Zion Cemetery Chaneysville, PA Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, Signature of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 21502 Part 1. E.t. r the disasse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** YRI SEVERE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2. ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tyes 2 No Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No 1 Natural 5 Pending Accident Investigation within 24 hours after deatl 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) of certifie nd tit 29d. Date signed (Month, Dav. Year TH Qus 1- ano 5 Som 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nds Robustiano J. Barrerá, M.D., 200 Glenn Street, Cumberland, MD 21502 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^MJan 2, 2012 5:00 AM^M Physician/ Easton Marie Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Allegany Cumberland 12916 N. Cresap St. Apt. 8 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth Social Security Numbe **Funeral** Country) WV Days Mav 29 ar)1923 88 Director 218-12-5075 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Sant: If item 27 is marked other than "natural", or items 23a or 28a-f shorinry or other traumatic event, the Medical Examiner must be notified at Funeral Director Cumberland Allegany 1 XYes 2 No MD 10f. Zip Code 10q. Citizen of What Country? 10e. Street and Number USA 21502 12916 N. Cresap St. Apt. 8 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give white 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Amanda unknown ၉ George Daniels 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 12916 N. Cresap St. Apt. 8 Cumberland 19a. Informant's Name/Relationship (Type, Print) MD 21502 Carleen Sines daughte 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition partment of h portant: If ite y injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Sunset Memorial Park 1/5/2012 MD Cumberland permit. Page Department of Important: If any injury or Donation 5 - Other Specify) 22. Name an Scarpeni Fulleral Home, PA Signature o Funeral Service 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardia disease or condition resulting in death) Medical Examiner years Generalized arteriosclerosis Section tially list concilions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or liniury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by atrial fibrillation, HTN 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe 1 Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 🗹 No 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 27. Manner of Death 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certif 2012 5 00017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nes avale, MD also2 922 Notion 20

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2^{Day} Jan. 2**0**₹2 Physician/ 507 Αм Ε. Francis Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Rockville Shady Grove Adventist Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Min 87 222-10-7153 1 🛂 M 2 🗆 F **Director** Dover, DE 1924 20, or 28a-f shov 10a. State 10c. City, Town or Location with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Clarksburg Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral US 20871 13431 Lewisdale Road hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc Armed Forces? ð 1 Never Married 2 X Married 1X Yes If Yes, Give White 1 🗆 Yes 2 🖁 No Year or Dates. 1951 Completed 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Electrical Electrical Enginer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Estella M. Coverdale ည Charles Erdle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any Miury or any 13431 Lewisdale Road Clarksburg, MD 20871 <u>Gilda Erdle</u> Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 Frederica, DE 7, 2012 Barratts Chapel llan. 4 Donation 5 Other (Specify) 1990122. Name and Address of Facility Signature of Funeral Service Lice 12 Lotus Street Dover, Trader Funeral Home, Inc. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ astrointestin 0 Medical resulting in death) Due to (or as a consequence of) Examiner 5431 Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed anemio Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical EI WOCH) Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 has 2 🗆 No 1 Yes certificate funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending the Funeral Director... 1 Yes 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2012 HILLES Janyar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Germantium MJ 2087U Doctor DVIVE 1912

Ε

State Registrar 31. Date filed (Monti

050

6

2010

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Norman W. Fox, Sr. January 2012 1901 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4915 Mount Zion Road Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 X M 2 - F Months Hours 84 December 25, 1927 Director 212-24-5243 Maryland 28a-f show 10a, State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** ms 23a or 28a-f s must be notified Maryland Frederick Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4915 Mount Zion Road 21703 United States of America Page 1 and 2 should be filed within 72 hours after death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten Examiner ı 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. X Yes 2 No 1946þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White If Yes, Give "natural" Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sargent United States Military 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Jacob Fox Elsie Mae Colb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Robert Fox / Son 22503 Cavetown Church Road, Cavetown, Maryland 21720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State January 17, Mount Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 2012 21. Signature of un rat Service Lie 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) (AMDIOVASCULAN Onset and Death Physician/ Therosche 20171 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to improvious cause. Enter Underlying Examine Dire to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No eral Director; After this certificate filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. hours after City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title o<u>f c</u>ertifie D0035152 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Frederik, MO LEGAR MO

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month January Physician/ 2012 7:05 AΜ FORCIER MARSHALL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours Oct. 25, 1927 1 M 2 7 F 84 Pennsylvania Director 499-34-1638 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 3200 Baker Circle Apt. 131 21710 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc. ģ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 4 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marian Deutsch John N. Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Fairfield Way SW Leesburg, Virginia 20175 1 and 2 s of Health item 27 John Forcier (Son) other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it ò injury o Smithsburg Crematory Jan. 8, 2012 Smithsburg, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Bastord P.A Funeral Home MO1612 106 E. Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myscardial Intertor disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): orten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner that the death certificate be executed use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Month Day Pregnant at time of death ed by the a detached for 1 ☐ Yes 2 pc 9 ☐ Unknown q I I Inknown P.O. s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy performed? Yes 2 N page 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🖄 Natural 5 Pending Division 2 🗌 No М 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 125 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD, MS D72399 15 en 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 w 7th St Feldman Frederick, MD 21701 Heret 31. Date filed (Month, Day, 32. Registrar's Signature State 2012 9 Registrar

DHMH 17 Rev 7/2009

12-00142 James Fisher

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

icuse i	Type of I fill ill black illdelible link. Ellouic All copies Ale Legible.	
	State of Maryland / Department of Health and Mental Hygiene	2010

		1- For State Registrar	Cei	tificate of	Death		Reg	2. No.	12 0101			
Physici		Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death			
ledical Exami	ner	James Roy Fishe	r, Jr.				January 5,	2012	0035 hrs			
		4a. Facility Name (if not institution, give s	treet and number)	41	b. City, Town, or I		1	4c. County of Dea Washington	ith			
		Meritus Medical Center	17. A - (l)		Hagerstown		In paragraphic		Sight along (Otata an			
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days		_	(MM/DD/YYYY) 9. E Fore	eign			
Director			2□F 90	Yrs.			April	9, 1921 °	Country) MD			
ROY		Usual Residence of Decedent 10a. State 10b. County	Inc City	Town or Location	nn .				10d. Inside City Limits			
≱ .,,									1 Yes 2 No			
Aaryland 28a-f show at oocc	ţ	MD Washingto	on	Hagers	10f, Zip Code		I 10	g. Citizen of What Co	•			
or 28	Director	17816 Rench Road			Tot. Zip Gode	21740	10					
eath with the Maryland items 23a or 28a-f sho sst be ootified at 00ce.	rai 🗅		2. Was Decedent Ever in U.	S 13 M/se	Decedent of Hisp		necify Ves or No.	U.S.A	erican Indian, Black,			
ath w	Funer	1 Never Married 2 Married	Armed Forces?		s, specify Cuban,			White, etc.	yroan maian, black,			
ter de 		3 Widowed 4 Divorced If	1 Yes 2 No Yes, Give Yeer	1	Yes 2 No	specify:		Specify: W	hite			
urs af Itural	d by	15. Decedent's Education (Specify only	r Dates:	16a, Decedent	s Usual Occupation	on (Give kind of		16b. Kind of Busines	s/Industry			
5-0036 led within 72 hours at Hygiene. other than "natural the Medical Examion	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working life.	DO NOT use ret	ired)					
036 ithin	ם	12		Co	onductor			Rail Roa	d			
215-0036 be filed within 7 tal Hygiene. rked other thae		17. Father's Name (First, Middle, Last)			1	8. Mother's Name	First, Middle, M	aiden Surname)				
2121 uld be fil Mental I marked	Be	James Roy Fishe	er, Sr.				rie Her					
ID 21215-00; should be filed within and Mental Hygiene. The marked other that event, the Med	P P	19a. Informant's Name/Relationship (Type		100	·			per, City or Town, Sta				
ore, MD 2 s: 1 and 2 shou's of Health and IN If item 27 is n		William E. Fisher /			Rench Re			MD 21740 20c. Location - City				
ore, Mes I and 2 of Health If item 2		1 Burial 2 Cremation 3		crematory or other		letery,	Date	200. Location - City t	ii Town, State			
imci Page ment tant:		4 Donation 5 Other Specify:	Re	st Have	n Cemete				n, Maryland			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other thao "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be outlifted at once		21. Signature of Funeral Service Licensed	XHIV		ame and Address	110		n Funeral	- 1			
	_	23a. Part I. Enter the disease, or complica	ations that caused the death	Do not enter the	01 Penns	ylvania	Ave., Ha	agerstown,	MD 21742 Approximate Interval			
Physician Madical		failure. List only one cause on each	line.			sud i as caldiac c	or respiratory arres	st, shock, of flear	Between Onset and Death			
Examiner			omplications of left she to (or as a consequence or		np fractures				Deaur			
		Sequentially list conditions, b.	(,								
	ē	if any, leading to immediate Du	e to (or as a consequence of	f):								
_	Examiner	(Disease or injury that initiated	e to (or as a consequence of	F)·					-			
ansit		events resulting in death) Last Du d.		,								
760, cate be executed physician and he burial - transi	Medical	UNPENDED	MENDED									
760, cate be physici he buri	ş	IF FEMALE:	23c. If yes, outcome of pregi	nancy				23d. Date of delive	ury I			
687 ertific ding p		23b. Was decedent pregnant in the past 12 months?	1 Live birth		aldeath 3	Ectopic pregna	ancy	Month	Day Year			
Box 687 death certification and for use as t	Sic	1 Yes 2 No 9 Unknown	4 Pregnant at time of de 9 Unknown	ath 5 Oth	er (Specify)							
O. B. trithe de by the	Physician		ontributing to death but not re	esulting in the un	iderlying cause gi	ven in Part I.	23e. Did tob	acco use contribute t	o the cause of death?			
r, P.O ires that t signed by	2			Ü	, ,		1 Yes	2 No 3 Pr	obably 4 🗹 Unknown			
rds, require been si hould b	Completed						24a, Was ar	24b. Were a	autopsy findings available			
law r has b	힐						autops: perform		completion of cause of			
tal Recition: The certificate	3	25.11					1 Yes 2	✓ No 1 1 .	Yes 2 No			
iciao iciao rector	æ	25. Was case referred to medical examiner?	pital: 1 ✓ Inpatient 2	FD/0 4		of Death (Check		o [7] ou				
of Vital Records, of Physiciae: The law require this certificate has been sineral director, page 2 should t	ဍ	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of Inj		4 Nursir		esidence 6 Oth	er.			
adiog h.: Aft	Certification:	1 Natural 5 Pending	Dec 15, 2011	0500 hrs		es 2 🗸 No	Subject fell	in injury cocurred				
Division tal or Attendic rs after death.	Sat	2 Accident Investigation	28e. Place of Injury - At ho	ome farm street			28f Location (St	reet and Number or F	Rural Route Number, City			
Division or At ours after decral Directifiled in by	늹	3 Suicide 6 Could not be determined	(Specify) Nursing Ho		, , ,		or Town, Sta					
Division of Vital Records, P.O. Box 687 24 hours after death. 2 hours after death. Fourtal Director: After this certificate has been signed by the attending retely filled in by the funeral director, page 2 should be detached for use as t		29a. Certifier	Da. Certifier a Continue Physician. To the best of my leavisides death accurred at the time date and place and due to the course) and the time date and place and due to the course).									
Di To the Hospital of within 24 hours at To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
To wit	Me	29b. Signature and title of pertifier	nd manner stated.		29c. License	number	- 1	29d. Date signed (M	onth, Day, Year)			
		M. I. K.	MI		O.C.N	M.E.		January 6, 2012	2			
A	ŀ	30. Name and address of person who con	npleted cause of death (Item	23a)								
3+1			stant Medical Examir		Baltimore St	reet, Baltimo	ore, MD 21223	3				
	ate	31. Date filed (Month, Day, Year) 201	2 32. Registrar's Signatu	A home	Kel							
Regist	rar	JAN 17 8 201	C Deneura 1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John William Ferrill 2012 2:46 P^{M} January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1923 Saratoga Drive Adelphi Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) June 27, . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F 89 1922 San Francisco, CA 567-28-0723 **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-i sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director event, the Medical Examiner must be notified Prince George's Adelphi 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1923 Saratoga Drive 20783 USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 K No Specify. If Yes, Give Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Sector Systems Analyst 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Harvey Ferrill Frances Buchanan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Lemmon Fletcher-Ferrill /Wife 1923 Saratoga Drive, Adelphi, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 X Burial 2 Cremation 3 Removal from State 2/16/2012 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. CAn Rosey 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Prostate Cancer Metastasis Years Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Failure, Ischemic Heart Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Yes 2 XNo death? 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? injury 5 Pending Accident nvestigation Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Children Prantiscer To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature And title of certifie 29c. License number AC000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CR-10+1

DHMH 17 Rev 7/2009

State Registrar

Reynolds

ANP-BC

Melanie

31. Date filed (Month, Day, Teal) JAN 0 6 2012

Basil

9200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Physician/ 2012 Annie Ruth Gray Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 Elkton Care and Rehabilitation E1kton If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** June 5, 1935 Hours 1 □ M 2 🗓 F Maryland **Director** 220-30-2611 76 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1 Yes 2 X No Maryland Ceci1 Rising Sun 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with United States 352 Fell Road 21911 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black. White, etc. Yes 2 X No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. White 3 X Widowed 4 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) al Hygiene. College (1-4 or 5+) Physical Therapy Assistant Health Care of Health and Mental Hyg item 27 is marked othe other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pearl Mae Bartlett Glen Elmer Doyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Janet E. Youse/Daughter 105 Farah Drive, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) January nk Cemetery | 18, 2012 | Calvert, MD

22. Name and Address of Facility Hicks Home for Funerals, P.A. Rose Bank Cemetery 21. Signature of Funeral Service Licensee 21921 103 W. Stockton Street, Elkton, MD 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ leans disease or condition resulting in death) Medical Examiner Temporava Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death g Unknown been signed by the s should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension. Diabetes Mellitus 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy death? performed' 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 \square Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Destinging Prostituation of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 1. 12.12

784

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY ΪΌ. 20T2 GONZALEZ 4:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 6. Sex 1 **X**M 2 □ F If Under 1 Year I If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country) Honduras Director 262-40-923 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Harford Jarrettsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1916 Belleguard Drive 21084 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🛚 Yes 2 🗆 No Specify: Honduran Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than "ron other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Retail Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Candido Gonzalez Nemencia Acosta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry A. Gonzalez 1916 (Son) Belleguard Drive Jarrettsville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan^{Date} 11, 20c. Location - City or Town, State ŏ permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll 2012 Cremation Hampstead, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final end stay Physician disease or condition resulting in death) ERL Medical Due to (or as a consequite of): Examiner Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) use as the burial-transit executed signed by the attending physician and dbe detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 ☐ Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🔲 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in rny opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) D32299 January 11, 201 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print DAVID DUNN 615 W. MACPHAIL ROAD BEL AIR, MD. 21014

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

IAN 1 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Month Physician/ Claudette Jane Greenwell 3:22 AM 1, January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's New Carrollton 7301 Sara Street 9. Birthplace (State or Foreign Country)
Parma, Missouri If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, ocial Security Numbe 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min. 1 🗌 M 2 🕱 F 300-32-0791 73 **Director** February Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland be notified at Director 28a-f New Carrollton 1 X Yes 2 No Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Funeral 23a 20784 USA 7301 Sara Street items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. "natural", or 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Own Home Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) r and Mental F ည Della Mae Martin Sidney E. Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau 7301 Sara Street, New Carrollton, MD 20784 Thomas J. Greenwell / Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1

■ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 1/6/2012 Clinton, Maryland Resurrection Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 KAL (Roger) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ terint 10 M40 10 years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending for use as IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Dav Pregnant at time of death ed by the a detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed? 1 ☐ Yes 2 ☐ No Yes 2 No certific 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural
2 Accident
3 Suicide
4 Homicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending death. Investigation 24 hours after deatl Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [within 2 To the 1 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21231 Baltmon, Armstrm 190 1650 Orleans Date filed (Month, Day, Year JAN 0 4 2012

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ellen Marie Green Month 8:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1124 Mary Drive 0akland Garrett Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 F Min. Hours 08 24 Yea Country) Director 213-64-7598 58 1953 Usual Residence of Decedent 28a-f show 10a. State 10b. County death with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Garrett 0akland ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1124 Mary Drive 21550 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

I is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) office manager medica1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas E. Green Della H. Upole Page 1 and 2 should I nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Mary Helms-sister Box 644, Capon Bridge, WV 26711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State Cumberland Crematory Cumberland, MD 1/14/2012 4 Donation 5 Other (Specify) 21. Signature Funeral Service 22. Name and Address of Facility David A. Burdock Funeral Home PA N 2nd St, Oakland, MD 21550 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ myocardia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying signed by the attending physician and defeached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \subseteq \text{ No} \) 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of after death.

Director: After this certificate has autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 **N**0 Other: မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident
3 Suicide 1 Yes 2 No Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined e Funeral I Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one)

State Registrar e and title of certifie

fonth, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Signa

mara

130

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend 25 per med cert G924 2 F25 Per All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012

For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Evelyn Earnestine GODLOVE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Reeders Memorial Home Boonsboro Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 M 2 X F Months 577-32-9464 Yrs. Director March Marvland Usual Residence of Decedent 28a-f shov 10b. County death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 141 S. Main Street 21713 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify item 27 is marked other than "natural", other traumatic event, the Medical Exa Specify 3 Divorced White Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 8 0 Homemaker Her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Garland Fleenor Thelma Hutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Lancaster - Daughter 4608 Mapleville Road, Boonsboro, Md. 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 ☐ Buria! 2 🗶 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 1/10/2012 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician BILLETY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MUMILED DONONTA Sequentially list conditions if cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Dav Year 1 Yes 2 9 Unknown signed by the Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

Yes 2 No 2 No certificate 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 XNo ၉ 1 Inpatient 2 ER/Outpatient 3 I 4 Mursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 4656 legu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ans Rd. Boonsboro MD State 10 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dorothy Marie Gross M January 2012 9:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Allegany Health Nursing & Rehab Ctr Cumberland 8. Date of Birth (Month, Day, Year) 08/30/1929 Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 🗓 F Days Hours 82 Director 214-62-4808 Marvland Usual Residence of Decedent 28a-f shov 10a. State Ħ 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director if than "natural", or items 23a or 28a-fs the Me It al Examiner must be notified 1 ☐ Yes 2 🗓 No MD Cumberland Allegany 10f. Zip Code 21502 10e. Street and Numbe 10g. Citizen of What Country? 15508 Baltimore Pike Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: 3

Widowed 4 □ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Aid other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H ပ Myrtle Belle Ammons Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 15508 Baltimore Pike, Cumberland, MD Richard W. Gross / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Hermon Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 01/12/2012 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) grature of Funeral Service Lic 22. Name and Address of Facility Adams Family Funeral Home, 21502 404 Decatur Street, Cumberland, MD Ŏ Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final CHRONIC OBSTRUCTIVE Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence oi): Exami or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of). resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an his certificate has bal director, page 2 sl autopsy 2 No 1 🗌 Yes 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work n 24 hours after death. e Funeral Director: Aft eleted filled in by the fur 1 Tes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hor To the Fune completed fi 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature hd title ♠f certifie Day, Year) 29d. Date signed (Month) Th 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robustiano J. Barrera, M.D., 200 Glenn Street, Cumberland, MD

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Marth Day, Year) 12

32. Registrar's Signature

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland / D		tment of F				giene Reg. No	201	2	0	085
		-	Decedent's Name (First, Middle, La.	st)						2. Date of De	ath			3. Time	of Death
	Physici		Doris Caroline (TDNEV						Month	Da	y Ye 2012		3:15	рм
400	/Medi Examir		4a. Facility Name (If not institution, giv			4	b. City, Town, o	r Location		January		. County of E		ريور	
	Exaiiii	iei	Northampton Mand)r			Frede	rick				Freder	ick		
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	je (In yrs. last birti		If Under 1 Year	If Under		8. Date of Bir (Month, Da	th	1 0		ace (State	e or Foreign
	Director		220-18-1867	□M 2X F	86	Yrs.	Months Days	Hours	Min.	Dec. 2	192	.5 Ma	ary1	and	
	p.		Usual Residence of Decedent					,							
	show	_	10a. State 10b. County		10c. City, Town	or Locat	tion						10		City Limits es 2 □ No
	Ba-f	Director	Maryland Washing	gton	Hag	erst									5 2 140
	ith th	<u>i</u>	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of Wha	t Count	'y?	
	ours after death with the Marylar ral", or items 23a or 28a-f show Examination and the confilment	Funeral	937 W. Washington			,		740_				USA			
	er de	ů.	11. Marital Status	12. Was Decedent Armed Forces? 1 ∐Yes 2 📉	Ever in U.S.	13. Wa	s Decedent of H es, specify Cuba	lispanic Oi an, Mexica	rigin? (Spe n, Puerto l	city Yes or No Rican, etc.))-	14. Race - A Black, V			
36	", or	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	NO	1 🗆]Yes 2 X ∏No	Specify	:			Specify:	Whi	Lte	
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Exerciting to multibe multiple at	ed	15. Decedent's Ed		I 16a	Deceder	nt's Usual Occup	ation			16b. K	and of Busin	ess/Indi	ustrv	
15	in 72 n "na n tin	Completed	(Specify only highest gra	ide completed)	ï	(Give kin	nd of work done NOT use retired	durina mos	st of workir	ng				,	
212	within jiene.	E	Elementary/Secondary (0-12)	College (1-4or	5+)	Hom	nemaker					Her ow	m h	ome	
	ifiled Hygi other	BeC	17. Father's Name (First, Middle, Last,	1				18. Moth	er's Name	(First, Middle					
an	id be lental ked o	To B	Jerry Everhart					Bes	ssie 1	Hendri	ckso	n			
Maryland	ges 1 and 2 should be filed within 72 hours after dea tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items or other traumatic event, it is in a fire first first.	-	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing /	Address (Street						te, Zip	Code)	
Ž	nd 2 alth a 27 Is		Thomas Gibney - S	Son	48	03 C	Cowmans	Ct. N	V. M	ount A	irv.	Marv1	and	217	71
ē,	s 1 a of Heal item othe		20a. Method of Disposition				ion (Name of tory or other place			ate		ocation - City			
e E	Page ent o nt: If ry or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Cedar L			i	1/13/	2012	Jana	retown	M	22771	and
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 Is any Injury or other tra <u>once</u> .		21. Signature of Funeral Service Licer		pedal L		Name and Addre			nnich l				aryre	and
ñ	Depar Impo any Ir		Wald Chal	<u>/_</u>		i	E. Wil							nd 2.	1740
			23a. Part 1. Enter the disease, or com	plications that cause	d the death. Do n	'								Approxim	nate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.	1	Dane	- water						Interval B Onset and	d Death
To Asset	/Medical		disease or condition resulting in death)	a. Due to (or x	consequence of	of):	Some	, ,					111	onthis	Toglar
	Examiner														
-		je.	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence o	of):									
	cutec nd ansit	Examiner	if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury that initiated events	c											
o,	an ar rial-tr		resulting in death) Last	Due to (or as	a consequence o	of):									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		_d											
9	ntifica ng ph as th	led						7777					-		
Вох	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	2□=	ctopic pregnanc	**				23d. Date o		ry	
. B	dear de att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death		other (specify) _	·y				Month		Day	Year
P.O.	at the de by the tached	ту	9 ☐ Unknown	9 🗆 OTIKTOWIT											
Ś	res that signed I be deta	by	Part II. Other significant conditions of	ontributing to death t	out not resulting in	the unde	erlying cause giv	en in Part	1.	23e. Did		use contribu			
ord	w require been siç should b	pa		.						1 🗆	Yes 2	10 No 3[] Proba	ably 4 □	Unknown
Records,	law re as be 2 sho	Completed								24a. Was		24b. Wei	e autop	sy finding	gs available of cause of
Ä	The I	E								auto perfo 1 □ Yes	psy ormed? 2 X N	dea	th?	a □ No	(cause of
ita		Be C	25. Was case referred to medical	,		_		26. Plac	e of Death	(Check only			163		
of Vital	Physician: r this certific ral director, I	TO E	examiner? 1 Yes 2	Hospital: 1 ☐ Inpati	ent 2 ER/Out	tpatient	3 □ DOA Oth	ner: 4 K) N	lursing Hor	me 5 ☐ Res	idence	6 ☐ Other	Specify	()	
0	ding Ph h. After th funeral	<u> </u>	27. Manner of Death	28a. Date of Inj (Month, Da	ury 28b. T	ime of	28c. Injui Wor			28d. Describe					
Division	Vtter dir dea h. ctor: Af y the fur	atic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	n	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-Jo-i y		Yes 2]No						
<u>Vis</u>	er de recto by th	tiţi	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of In	ury - At home, far c. <i>(Specify)</i>	m, street	t, factory, office		2	28f. Location City or To	Street a	nd Number (or Rura	Route No	umber,
ō	spital or Atteridi nours : fter death. neral uirector: / / filled in by the ft	Certification:		Danding, 6							, 5101				
	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune			nysician: To the best niner: On the basis											e(s)
	To the Hos within 24 h To the Fun completely	Medical	one)	and manner st			onganon, m my (Aut Goodiff	ou at the time					
	To the I within 2. To the I complet	Σ	29b. Signature and title of certifier	111		20	29c. Licens		100			ate signed (/		Jay, Year))
		1	1 Wille			· 124	D	264	49		/	- 9.	- /	2	
			30. Name and address of person who	completed cause of	death (Item 23a) (Type, Pri	int)				61				20
I	U- 4	9 6	Ronald E. Miller		Cullwell	Dri	ve, Mou	nt Ai	Lry,	Md. 21	771				
	Sta	te	31. Date filed (Month, Day, Year)	017 32. B gist	rar's Signature	1	- c4 A								

DHMH 17 Rev 1/2001

12-00174 Diane Glovd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Diane Gloyd	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2012 010
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year
)	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Funeral Director	12831 Draper Road Clear Spring Washington 5. Social Security Number 212-82-7904 The security Number of State or Spring 7. Age (In yrs. last birthday) 1 Months Days Hours Min. The security Number of State or Spring Spring State or Sp
ж алу	Usual Residence of Decedent 10a. State
suth with the Maryland items 23s or 28s-f show ast be notified at once.	10e. Street and Number 12831 Draper Road 10f. Zip Code 21722 10g. Citizen of What Country? U.S.A.
s after de ral", or niner m	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done) 16b. Kind of Business/Industry
5-0036 cled within 72 hour otygiene. the Medical Exact Completed	Elementary/Secondary (0-12) College (1-4 or 5+) assembly worker medical supply co
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than the event, the Medical FO Be Comple	17. Fether's Name (First, Middle, Last) James Shelby 18. Mother's Name (First, Middle, Maiden Surname) Esther Marie McAllister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nore, MD 21 ggs 1 and 2 should nt of Health and Me t; If item 27 is ma other traumatie ev	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 2 Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr	1 Burial 2 Cremation 3 Removal from State Smithsburg Cremator Ty 1 2012 Smithsburg, MD 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee Mol 4/4 Donald Edwin Thompson Funeral Home, Inc.
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Description of the property of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart selections. Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
ted 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):
execulan and all - tra	d AMENDED AMENDED
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buriedical Certification: To Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
Division of Vital Records, P.O. Italor Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detache sartification: To Be Completed by Plearification: To Be Completed by Plearification:	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 124b. Were autopsy findings available
Vital Records, I yaician: The law requires his certificate has been sig director, page 2 should be OBE Completed	autopsy performed? 1 ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)
f Vital Physician: r this certi ral director	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 ✓ Other: Scene
ttending Ph death. stor: After t / the funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? FOUND: 1130 hrs 28d. Describe how injury occurred Subject hanged self
Division o Biopital or Attending 24 hours after death. Funeral Director: Aftered filled in by the funeral Control of the funeral Director.	3 Suicide 6 Could not be determined (Specify) A shed 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 128f. Location (Street and Number or Rural Route Number, City or Town, State) 12831 Draper Road, Clear Spring, MD
To the Hos within 24 h To the Fun completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	O.C.M.E. January 7, 2012
IW-1	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State Registrar	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAmend#23b.PerPhys.PGC1-6-12cr Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1336 Matthew Ginyard 2012 unuary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital 19Koma Park Montgomer 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 04/26/1932 VA Director 577-46-9693 Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10d. Inside City Limits Director DC Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3346 Blaine Street, NE 20020 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10th College (1-4 or 5+) Federal Protective Officer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eulishus Ginyard Emma Odoms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janie Thompson/Sister 1746 Stanton Terrace, SE, Wash., DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State Adelphi, MD 4 Donation 5 Other (Specify) George Washington 1/9/2012 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Lice 5538 Marlboro Pike, Forestville, MD 20747 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Immediate Cause (Final Onset and Death f flysician/ Myocardia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ ronony arteny diseas 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pertension autopsy perform Atrial Fibrillation 2 200 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 🗌 No 1 Inpatient 2 XER/Outpatient 3 IDOA After this nner of Death funeral 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending nours after death.

Neral Director: A

filled in by the fu 1 🗌 Yes 2 No Accident Investigation

Could not be Suicide 6 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and #tle of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ambar Morsha

6 2012

6700 Carrol

69194

Arenue takoma park Manyland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>012</u> Physician/ January 2 11:33A M Ann Gardner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital Center Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. Hours Director 579-46-0451 1 🗆 M 2 🗶 F 5/11/1936 Washington, DC Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified 1 Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Completed by Funeral 20602 USA 3033 October Place Apt. E permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Mental Hygiene. Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f Health and Merical item 27 is marked of မ Andrew Chamberlain Mave Belle Ward Arthur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26801 Frontier Lane, Mechanicsville, MD 20659 Lee Ann Lawson/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/9/2012 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745 23a. Part 1. Ener the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ 50 disease or condition resulting in death) Medical Examiner Due to (or as a consequence of Chruni Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 toknown After this certificate has been signature of the sector, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 Yes 2 No 1 Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 2 🗌 No Accident Investigation 24 hours after death Funeral Director: 6 Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

JAN 0 8 **2012**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State	ate of Maryland		rtment of F tificate of D			iene _{eg. No.} 20	12	01089	
	Dhysisis	_	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time of Death	
	Physicia Medic	al .	CARLETTA BLANCHE 4a. Facility Name (if not institution, give street)	HARRYMAN		4b City Town or	Location of Death	JANUAF		2 6	:45 P M	
	Examin	er	FREDERICK MEMORIAL			FREDE				ERICK		
	Funeral Director		5. Social Security Number 6. Sex 1 1 M :	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Dec 24,	^{Year)} 1928	g. Birthplace Country Mary	e (State or Foreign Land	
		_ h	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10d.	Inside City Limits	
	//arylar //as-f sh tified a	Director	MD Howard			Mt. A	iry				1 ☐ Yes 2 🏝 No	
	h the N 3a or 2 be no	al Di	10e. Street and Number			10f. Zip Code	771		10g. Citizen of V		?	
	ath wit	Funeral		as Decedent Ever in U.S	. 13. V	Vas Decedent of Hi	.771 spanic Origin? (Sp	ecify Yes or No-		A - American	Indian,	
36	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show other than "natural", or items 2a no tale of show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1	rmed Forces? ☐ Yes 2 ½ No Yes, Give		Yes, specify Cuba		Rican, etc.)	Specify:	k, White, etc. Wh :	, White, etc. White	
9	hours natura dical E	ete	15. Decedent's Education			ent's Usual Occup		king	16b. Kind of Bu	usiness Indus	try	
21215-0036	thin 72 ine. than "I	Completed	(Specify only highest grade college of the college	ollege (1-4 or 5+)	life. DO	NOT use retired) Homema	_	NIIG	Own	n Home		
<u>5</u>	filed wit al Hygie d other event, th	Be	17. Father's Name (First, Middle, Last)			Homema		ne (First, Middle, i				
Maryland	uld be f Menta narked natic e	욘	John Thomas Roach					a Cathe				
	12 should lith and Me 27 is mar		19a. Informant's Name/Relationship (<i>Type, Pr</i> Judith Sharp/Daugh	•		g Address (Street a					e)	
\succeq	of Health of Health of item 27 or other tra		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Remo	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other plac	Jan	Date 14,	20c. Location -	City or Town	, State	
<u>E</u>	permit. Page Department o Important: If any injury or once.		4 Donation 5 Cther (Specify) 21. Signature of Fune & Service Lice see	Mic		wn Cem Name and Addre	2(012	Freela			
Ba	permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic eventone.		21. Si hature of Pune de Service Con see		24	N. Sec	cond St	. New F	reedon	PA	17349	
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	ons that caused the death ase on each line.	n. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	In	pproximate terval Between nset and Death	
	Medical		Immediate Cause (Final disease or condition resulting in death)	Advanced Due to (or as a consequ		angio Ca	minomo	\				
	Examiner	<u>.</u>	Sequentially list conditions, b. —							_		
	ted	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Due to or as a consecu	ience of							
	cate be executed physician and the burial-transit	al Ex	that initiated events c. — resulting in death) Last	Due to (or as a consequ	ience of):							
760	cate be physic s the bu	edical	d									
89	ath certifica attending p	an/M	23b. Was decedent pregnant	ryes, outcome of pregna ☐ Live Birth 2☐ Feta		☐ Ectopic pregnan	Cy			ite of delivery	Veer	
Division of Vital Records, P.O. Box 687	the att	Physician/M		Pregnant at time of o	death 5	Other (specify) _			IVIC	onth Da	ay Year	
P.0	requires that the de been signed by the should be detached	by Pr	Part II. Other significant conditions contribu	iting to death but not res	ulting in the u	ınderlying cause gi	ven in Part I.		bacco use cont			
rds,	equires	eted	Hypertension					1 L			oly 4 Unknown	
(eco	he law i te has t age 2 s	Completed by						autor	rmed?		eletion of cause of	
tal F	ctor, pa	Be C	25. Was case referred to medical examiner?	tol		Lau	lace of Death (Che		2 4 10			
Ž	Physic r this co ral dire	은	1 L Yes 2 LLATO	1 Inpatient 2 I	28b. Time o	28c. Inju	4 ∐ Nursing F y at	Home 5 Resid	dence 6 Oth			
ouo	ttending death. stor: Afte y the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1 🗆	k? Yes 2 No					
ivisi	l or Attu after de Directu	Certi	3 Suicide 6 Could not be 4 Homicide determined	Street and Numb n, State)	er or Rural Ro	oute Number,						
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician (Check 2 Medical Examiner: C	: To the best of my know	ledge, death	occured at the time	e, date and place,	and due to the ca	use(s) and manning place, and du	ner as stated.	e(s) and manner stated.	
	o the Hithin 24 o the Formplet	Me	only one) 3 Certifying Nurse Pra	ctioner: To the best of m	y knowledge,	death occurred at ti	ne time, date and pl	lace, and due to th	e cause(s) and m 29d. Date signe	anner as state	ed	
0	I A		1 des in			65	183		01/1	0/20	12	
	Ogh	1	30. Name and address of person who compl		23a) (Type,	Print)	1=nodo	71. 4	10 21	701		
	Sta	te	31. Date filed (Month, Pays Year)	32. Registrar's Signa	ture de	reet,	1 Teaes	rick, M	11) 61	()		
	Registr	ar	AWIN TO FOIL	Acres 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Brenda Ann Horn		1- For State Registrar	tate of Maryla		artment o ertificate o		and Men		Reg. No. 20	12 0109		
Physicia Medical Examin	-	Decedent's Name (First, Middle) B1	_{dle,Last)} renda Ann	Horne-W	illiams	3		2. Date of De Month January		3. Time of Death 0022 hrs		
		4a. Facility Name (if not instituti Laurel Regional Medi		umber)		4b. City, Town	, or Location of		4c. County of Prince Ge			
Funeral Director		5. Social Security Number 578-70-0518	6. Sex	7. Age (In yrs. 58			Year If Under		28, 1953	9. Birthplace (State or Foreign Country) DC		
Maryland 28a-f show any datonce.	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number			, Town or Loca	10f. Zip Coo	<u>Capit</u>	ol Heights	10g. Citizen of What	10d. Inside City Limits 1 Yes 2 No Country?		
er death with	by Funeral Di		Arried 12. Was Dec Armed Fi 1 Yes vorced If Yes, Give Yea or Dates:	2 X No			ban, Mexican	3 gin? (Specify Yes or N , Puerto Rican, etc.)		ed States American Indian, Black, etc. Black		
7	mpleted	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12th	College (1			nost of working	ife DO NOT 11 Bill	ing		vate		
21 be fill rked	å	17. Father's Name (First, Middle, Last) Fletcher Horne 18.Mother's Name (First, Middle, Maiden Surname) Dillie Stroman										
iti iti i	٩	19a. Informant's Name/Relationship (Type, Print)19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, ZBernard Horne - Brother1812 Hollydale Road Ft. Washington, Md.										
re, l s l and f Healt ffitem	Ī	20a. Method of Disposition 1	n 3 Removal fr		Place of Dispos crematory or of		cemetery,	January 19				
Baltimore, permit. Pages I an Department of Hee Important: If ite injury ar ather tr		4 Donation 5 Other S 21. Signature of Funeral Service	Licensee V	ww		Name and Add		2012 Stewart Fundad NE Wash	neral Hon			
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	e on each line. e a. Hypert	ensive	Atheros	he mode of dy	ing, such as ca		rest, shock, or heart			
		or condition resulting in death) Sequentially list conditions,	b	consequence of								
	튑	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	С.	consequence of								
6 be executed sysician and burial - transit	ij.	events resulting in death) Last	d	consequence o								
50, ite be exe nysician i	Medical	X UNPENDED F FEMALE:		23a,pt.		oer me,	g923 1-	-24-12 sm	23d. Date of de	livon		
Box 6876(e death certificate the attending phy- ed for use as the b	Clan	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	he 1 Live b	oirth ant at time of de	2 🔲 Fe	etal death ther (Specify)	3 Ectopic	pregnancy	Month	Day Year		
S, P.O. E uires that the d n signed by the ld be detached	~	Part II. Other significant condit		death but not r	esulting in the I	underlying caus	se given in Pa	1 Ye	es 2 No 3	te to the cause of death? Probably 4 Unknown		
	Сошріете	25. Was case referred to medica	al			26 01	age of Dooth /	24a. Was auto perfu	psy prio ormed? dea	re autopsy findings available or to completion of cause of the completion of cause of the completion o		
Physician er this cer	ă o L	examiner? 1 ✓ Yes 2 No	[Hospital:	npatient 2	ER/Outpatient		IOther -	Nursing Home 5	Residence 6	Other:		
Division of tall or Attending Photal or Attending Photal and Director: After I led in by the funeral or the tall o		27. Manner of Death 1 X Natural 5 Pend 2 Accident Inve	ding stigation	, Day,Year)	28b. Time of I	1	njury at Work	No	how injury occurred			
Divis	E L	4 Homicide dete	Homicide determined (Specify)									
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filted in by the	ē ['			of examination a				ce, and due to the cau				
F 3 F 5	¥	29b. Signature and title of certific		B			ense number C.M.E.		29d. Date signed January 6, 20	(Month, Day, Year) 012		
R	-	30. Name and address of person Melissa Brassell, MD		,		/. Baltimore	Street, Ba	altimore, MD 212	23			
Stat Registra		31. Date filed (Month, Day Year)	Serena 32. Re	gistrar's Signat	all							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ 0535 M anuas Medical 4a. Facility Name (if not institution, give streat and number) Town, or Lecation of Death Examiner HADRESTOVIN TUS PN WOSTIN 8. Date of Birth (Month, Day, Year If Under 24 Hrs. **Funeral** Social Security Number Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 🛣 M 2 🗆 F Hours 199-26-3232 **Director** 80 1931 Watertown. Usual Residence of Decedent 28a-f shov at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1x Yes 2 □ No Franklin Waynesboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 120 Coquina Sands Dr. 17268 US death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 2 1 Never Married 2 XMarried 1 X Yes 2 □ No If Yes, Give 1955-1962 Year or Dates. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. white Specify: "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) catalog store owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Julius A. Hirt Jessica A. Boyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor M. Hirt 120 Coquina Sands Dr. Waynesboro, PA 17268 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/3/2012 1 Burial 2 Cremation 3 Removal from State Waynesboro, PA 4 Donation 5 Other (Specify) Cumberland Valley Crematorium 22. Name and Address of Facility . Signature of Fun ral Service Licen Grove-Bowersox Funeral Home, Inc. 50 S. Broad St. Waynesboro, PAPart 1. Enter the disease, or complications that caused the death. Do not a ter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Physici_n/ disease or condition resulting in death) > Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 1 Yes 2 9 Unknown detached 9 Unknown signed by till to be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performer 1 \(\text{Yes} Yes 2X the Hospital or Attending Physician: I hin 24 hours after death. the Funeral Director; After this certifies 25. Was case referred to medical examiner?

1 Yes No Be 26. Place of Death (Check only one) မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred X Natural injury 5 Pending 2 No Accident Investigation completed filled in by the 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifige 29c. License number 29d. Date signed (Month, Day, Year) 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATON 32. Registrar's Signature State JAN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Devon Elizabeth Harvey State of Maryland / Departr

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 01092

OCNE

		Registrar Certificate of Death Reg. No.												
Physici odical Exam		Decedent's Name (First, Middle, Devon Elizabet	th Day Yea , 2012	ir	3. Time of Death 1217 hrs									
		4a. Facility Name (if not institution, Meritus Hospital	give street and number)		4	b. City, To Hagers		ocation of	Death		4c. County o		1	
Funeral Director				In yrs. last birthd	ay) Yrs.	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	→ ` 1.			thplace (State or gn untry) PA.	
ow any		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or									10d. Inside City Limits 1 X Yes 2 No	
death with the Maryland or items 23a or 28a-f show must be notified at once,	Director	Maryland Washi	ngton	Hagers	tow	n 10f. Zip C	ode			1	0g. Citizen of Wh	nat Cour		
rith the ? 5 23a or 2 notifie	al Dir	1020 S. Potomac	Street	ver in IIS 11	2 M/20		2174		n2 / Snan	ify Yes or No	USA lo- 14. Race - American Indian, Black,			
0036 within 72 hours after death with the Maryland giene. ter than "aatural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	Funeral	1 Never Married 2 X Marr	ried Armed Forces?] No	If Ye	s, specify	Cuban, f	Mexican, F			White Specify:	e, etc.	nite	
hours af 'natural Examin	ted by	15. Decedent's Education (Specification)	or Dates:	eted) 16a. De	16a. Decedent's Usual Occupation (Give kind of volume during most of working life. DO NOT use reti					(work done 16b. Kind of Busines			ndustry	
imore, MD 21215-0036 Pages I and 2 should filed within 72 hours after ment of Health and Monduel Hygiene and faster If tiem 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12)	.al <i>A</i> .ons	Assistance										
21215-0036 21215-0036 build be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, La	•						,		Maiden Surname	1		
D 21215- should be filed and Mental Hyg 7 is marked oth	To E	Phillip Warren Hornbaker 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Harvey - Husband 1020 S. Potomac Street, Hagerstown, Md. 21740												
re, MD I and 2 sho Health and fitem 27 is		Christopher Harv 20a. Method of Disposition 1 Burial 2 X Cremation		20b. Place of D	Disposit	ion (Name				Hage	20c. Location -			
Baltimore, permit. Pages 1 an Department of Hea Important: If ite		4 Donation 5 Other Spec	cify:	1	towi	n Cre	matc	ry					, Maryland	
Balti permit. Departu Import injury		21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Marylan												
Physician Medical		Approximate Interval failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone Overdose Approximate Interval Between Onset and Death Death												
žxaminer.		or condition resulting in death)	Due to (or as a consequ									_		
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	uence of);										
uted id ansit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ience of):										
3760, ficate be executed g physician and s the burial - transit	an/Medical	X UNPENDED	7.111.2110.20	27,28a-	E,po	er me	,g92	25 3-	7–12	sm				
2 E E E		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth Pregnant at tim	2	Ξ	il death		Ectopic p	oregnancy	,	23d. Date of Month) Day Year	
Box le death of the attented for us	Physici	1 Yes 2 No 9 V Unkno	9 Unknown			er (Specif)					100			
i, P.O. Box 6 ires that the death cer signed by the attend the detached for use	by	Part II. Other significant condition	ns contributing to death b	ut not resulting in	the un	derlying ca	use give	en in Part	1.			_	the cause of death?	
cords, law requir has been s	Completed						_			24a. Was autop	sy p		topsy findings available ompletion of cause of	
tal Rec	Be Cor	25. Was case referred to medical				26.	Place of	Death (C	heck only	1 Yes		Ye	s 2 No	
Vita bysici this c	0	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpa	atient	3 DOA	Ot	her4 🔲 N	Nursing H	lome 5	Residence 6	Other:	:	
Division of Vital Records, P.O. also ratending Physician: The law requires that the start death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig				i .	_ `	at Work? s 2 🔀 N		d. Describe h	now injury occurre	∌d		
Divis nital or At urs after d rral Direc	Certification:	3 Suicide 6 X Could n 4 Homicide	not be 28e. Place of Injury	r - At home, farm Resid			fice buil	ding, etc.		or Town, S	tate) 428 W.	r or Rur , Was	ral Route Number, City shington St.	
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attend completely filled in by the funeral director, page 2 should be detached for use	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	Me	29b. Signature and title of certifier	1111	4			icense r				29d. Date signe			
300		30. Name and address of person who Zabiullah Ali, M.D. As	no completed cause of deal	, ,	N Ra	ltimore	Street	Baltim	ore M	D 21223				
St Regist		31. Date filed (Month, Day Year)	32. Registraris				J. 1001	, -aitiiii	.5,5,141					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

effrey B. Hudso	n	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.											
Physicia ledical Exami		Decedent's Name (First, Midd Jeffrey B. Hi	udson	-					Date of Deat Month January 6,	h	3. Time of Death 1836 hrs		
•		4a. Facility Name (if not institution Baltimore Washington	on, give street and number	-)		4b. City, Town, o Glen Burni		Death	,,,,,,,	4c. County of De			
Funeral Director		5. Social Security Number 213–17–8746	6. Sex 7. A	ge (In yrs. I	last birthday)	If Under 1 Ye Months Da		24Hrs. Min.		h(MM/DD/YYYY) 9. 29, 1977	Birthplace (State or reign Country) Maryland		
ɗaryland 28a-f show any 1 at once.	or	Usual Residence of Decedent 10a. State 10b. County MD Anne	Arundel		Town or Local						10d. Inside City Limits 1 Yes 2 X No		
death with the Maryland rritems 23a or 28a-f tho nust be notified at once.	I Director	10e. Street and Number 116 Furnlea Di	rive			10f. Zip Code	1060		10	10g. Citizen of What Country? USA			
- G 14	by Funeral	3 X Widowed 4 Div	orced If Yes, Give Year	? X No	1f Y	as Decedent of Hi es, specify Cuba	n, Mexican, F	Puerto Rio	can, etc.)	White, etc	hite		
nore, MD 21215-0036 rages I and 2 should be filed within 72 hours after nor of Health and Mental Hygiene. st: If item 27 is marked other than "natural", cother traumatic evect, the Medical Examiner.	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12)	College (1-4 or 2			nt's Usual Occupa lost of working life Landsca	DO NOT us			16b. Kind of Busine: Landso	caping		
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than cevot, the Medica	To Be Co	17. Father's Name (First, Middle, Last) Jeffrey Hudson 18. Mother's Name (First, Middle, Maiden Surname) Lea Schell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,											
2 0 4 0 E		Jeffrey Hudson 20a, Method of Disposition 1 Burial 2 Cremation		ate (522 F Place of Dispos crematory or oth	orest V	iew Ro		inthic		s, MD 21090		
Baltimore, permit. Pages I and Department of Heall Important: If item injury or other tra		4 Donation 5 Other Sp. 21. Signature of Foreral Service	pecify:	12 A. Sev		K Funeral Hom							
Physician /Medical Examiner		23a. Pic I. Enter the Isease, or failure. List only one cause Immediate Cause (Final disease	on each line.		. Do not enter ti		LE HWY , such as card	diac or re	Set spiratory arre	verna Parl st, shock, or heart	Approximate Interval Between Onset and Death		
	ner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a cons b. Due to (or as a cons										
ecuted and transit	I Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	equence of	f):					_			
be ex ician	Medical	X UNPENDED IF FEMALE:	AMENDED 23a			8a-f,per	me,g	923 1	-24-12	23d. Date of deliv	erv		
Division of Vital Records, P.O. Box 68760 (optial or Attodiog Physiciae: The law requires that the death certificate b hours after death. **newral Director: After this certificate has been signed by the attending physicial birector: After this certificate has been signed by the attending physicial birector, page 2 should be detached for use as the bu	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk	4 Pregnant at	time of de	ath -	al death 3	Ectopic p	regnancy		Month	Day Year		
duires that the en signed by the detach	[ব	Part II. Other significant conditions Cardiomegaly	ons contributing to deat	n but not re	esulting in the u	nderlying cause (given in Part I		1 Yes	2 No 3 Pr	to the cause of death?		
of Vital Records, P.O. S. Physiciae: The law requires that the there his certificate has been signed by neral director, page 2 should be detach	Completed	OF Management and the second s							24a. Was ar autopsy perform 1 Yes 2	y prior to ned? death?			
F Vital Physiciae This cert al directo	قا و	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	-	ER/Outpatient	3 DOA	of Death (Ch	heck only lursing Ho		esidence 6 Oth	ner:		
Division of tal or Atteoding Programs after death. 1 Director: After led in by the funera	Certification:		tigation td 1-6-	ear) -12	28b. Time of Ir	pm 1	ryatWork? ∕es 2. XX No	。 u	nknown				
Division To the Hospital or Atteod within 24 hours after death To the Fuorral Director: completely filled in by the		4 Homicide deter	mined (Specify)	Res	sidence	t, factory, office b		G1	or Town, Sta Len Bur	nie.Md.			
To the E within 2. To the F complete		(Check only one) 2 Medical Exar 29b. Signature and title of certifier	ysician: To the best of miner: On the basis of examend manner stated	nination ar	nd/or investigati	ed at the time, da on, in my opinion 29c. Licens	, death occur	, and due red at the	time, date ar	nd place, and due to	the cause(s)		
		in h	3.07		22-1	O.C.I			1	29d. Date signed (M January 7, 201)			
40		30. Name and address of person Ling Li, MD Assistar 31. Date filed (Month, Day, Year)	who completed cause of d nt Medical Examine 32. Registral	900 V	V. Baltimore	e Street, Balt	imore, MD	21223	3				
Sta	Œ.	Date med (Month, Day, Year)	1 2011	s signatul	- 4 /	1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 28 Jeffrey Alan Higgins 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Aug. 26, 1960 Maryland 219-72-8301 51 Director 1**XX**M 2 □ F Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Wester Director 1 Yes 2 No Falling Waters 28a-f Mirginia Berkeley 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must be Funeral 23a 29 Shaffer Drive Apt. 25419 items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ò 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify "natural", Completed 3 Widowed 4X Divorced 1984 White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Concrete Supplier Truck Driver Be Department of Health and Merial H Important: If item 27 is marked oth any injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Russell Higgins, Sr. Rita Delores West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14011 Seneca Ridge Drive Hagerstown, Maryland 21740 John Higgins- Brother 20a. Method of Disposition

Buria 2 1 Crema 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) val from State 4 Denation Jan.9,2012 Williamsport, Maryland 5 \ Oti Greenlawn Mem. Park Osborne Aftereitaliy Home, P.A. 425 S. Conococheague St.Williamsport, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician 6 Ma disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death signed by the ard d be detached for Yes 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate Foompletely filled in by the funeral director, pag 1 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur 01 ress of person who completed cause of death (Item 23a) (Type, Print) 141 Q State 9 Registrar

12-00235 Ruth Anna Hollin		vorth St	pe or Print i	and / Depa	artment o	of Health				egibl		112	2 0109
		1- For State Registrar		Cei	rtificate c	of Death				Reg. No		1 2	_ 0107
Physicia		1. Decedent's Name (First, Midd							Date of D Month	Day	Year		3. Time of Death
Medical Examin	ner	RUTH ANNA HOLL							January	8, 201	12		2155 hrs
		4a. Facility Name (if not institution 12344 Chesterville Ro		umber)		4b. City, Tov Galena		cation of Deatl	1	4c. County of Death Kent			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. l	ast birthday)	If Under	1 Year	If Under 24Hr	s. 8. Date of	Birth (MN	M/DD/YYYY)		hplace (State or
Director		221-12-8420	1 M 2 X F		86 Y	Months s.	Days	Hours Mir	08/2	2/19	125	Foreign	n LAWARE
		Usual Residence of Decedent							100/2	2/1/	/23	DIL	
и апу		10a. State 10b. County		10c. City,	, Town or Loca	ation						ı	10d. Inside City Limits
land f sho	ē	MD KENT		GAI	LENA								1 Yes 2 No
-death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number				10f. Zip Co	ode			10g. Ci	itizen of Wha	at Coun	try?
th the		12344 CHESTERV				2163					TED S		
ath wi	Completed by Funeral	11. Marital Status 1 Never Married 2 M	arried 12. Was De					nic Origin? (S lexican, Puerto		No-	14. Race - White,		can Indian, Black,
ter de	리	3 X Widowed 4 Div	1 Yes	2 X No	1	Yes 2	l No. s	snecify:			Specify W	וידידיו	7
urs af tural	힐	15. Decedent's Education (Spe	or Dates:					(Give kind of	work done	16b.	Kind of Bus		
72 ho	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)	during r	nost of working	g life. De	O NOT use ret	ired)	1			-
036 rithin ne. r tha	핕	10			HOMEM	ÍAKER					OWN :	номі	Ξ
5-0 lied w Hygic		17. Father's Name (First, Middle	Last)				18.	Mother's Name	First, Middle	, Maide	n Surname)		
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. a 77 is marked other than numatic event, the Medica	B	JOHN JAMES DEN						ELLEN M					
D 2 should and M	٤	19a. Informant's Name/Relations		an				nd Number or					
imore, MD 21215-0036 Reges I and 2 should be filed within 72 hours after death with the Maryland ment of Reath and Mental Hygiene. Lant: Witem 27 is marked other than "natural", or items 33a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	1	REBECCA KIRAYO 20a. Method of Disposition	GLU / NIE		Place of Dispo			AVE. #3	Date		Location -		
Baltimore, oermit. Pages I ar Department of the Important: If the Important: If the Injury or other tr		1 Burial 2 X Cremation	3 Removal f		crematory or o			.				•	
timent the street of the stree		4 Donation 5 Other St. 21. Signature of Funeral Service		CHI	ESAPEAK			ON 01/	12/201	2 S			LLE, MD
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and Iv Important: If item 27 is m injury or other traumatic.		21. Signature of Fulleral Service	Licensee		FE	LLOWS,	HEI	FENBEI	N & NE	WNAM	I FUNE	RAL	HOME, P.A.
Physician	\dashv	23a. Part I. Enter the disease, or		aused the death.	. Do not enter	the mode of d	YPKI lying, suc	ESS ST. ch as cardiac o	MILLI. or respiratory a	NGTO arrest, sh	nock, or hea	_∠⊥t rt	Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease	A 411	rotic Cardiov	ascular Dis	Sease							Between Onset and Death
Examiner	- [or condition resulting in death)		a consequence of		Jeuse	-	•••					
		Sequentially list conditions,	b										
	i.	if any, leading to immediate causa. Enter Underlying Causa.	Due to (or as a	a consequence of	f):								
sit d	Examiner	(Disease or injury that initiated events resulting in death) Last		a consequence of	f):								
2 2 2	=1.	- Lungsupen	d										
O, e be e: /siciar	ed G	UNPENDED	AMENDED		-					- 12			
876 tificat ng phy as the	[]	IF FEMALE: 23b. Was decedent pregnant in the	e 23c. If yes,	outcome of pregr pirth	. —	etal death	3	Ectopic pregna	ancy	23	3d. Date of o Month	-	ay Year
th cer trendi	흥	past 12 months?		nant at time of de	ath -	ther (Specify)						
Bo he dea / the a	Physician/Medica	1 Yes 2 No 9 V Uni	3 OUNT						Log B:				
P.C.	ক্র	Part II. Other significant condit	ions contributing t	o death but not re	esulting in the	underlying ca	iuse give	en in Part I.		_		_	he cause of death?
ds, equire een siq	Completed		····						24a. Wa	is an	24b. W	ere aut	opsy findings available
COF	흵									opsy form <u>ed</u> ?		ior to co eath?	empletion of cause of
Re: The iffcate	ខ្ញ	OF Manager referred to medical				26.1	Diago of	D#- (Ob)		2 🗸 1	No 1 [Yes	2 No
lital sician is cert	ď,	25. Was case referred to medica examiner?	Hospital:	Inpatient 2	ER/Outpatien			Death (Check ^{ner} 4 Nursir		Resid	lence 6 🗸	Other	Scana
of V g Phy Rer th	잂	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of			nt Work?	28d. Describ				CCCTIG
OD OD on ath.	힐	1 Natural 5 Pend	ling	n, Day, Year)		1	Yes	2 No					
viSi or Atta ter de lirecte	<u>[</u> 2		stigation 28e. Plac	e of Injury - At ho	ome, farm, stre	et, factory, of	fice build	ding, etc.			and Number	r or Rur	al Route Number, City
Div pital o purs af	Certification:		mined (Specify)						or Town	, State)			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:			nysician: To the be										
To th withir To th	Medical	one) 2 Medical Exa	and manner s	of examination ar stated	nd/or investiga				at the time, da				
	2	29b. Signature and title of certifie	1/1				cense n						th, Day, Year)
		The Bras	self. Ille	<u> </u>).C.M.E			Jar	nuary 9, 2	2012	
		 Name and address of person Melissa Brassell, MD 	who completed cau Assistant Me		000 1	V. Baltimo	re Stre	et, Baltimo	re. MD 211	223			
Sta	ite:	31. Date filed (Month Day Year)	100 0	7	ire A	v. Baitimoi			. 2, 211				
Registr		JANA	1 2012	gistrar's Signatu	1. 18								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Lois Todd Irwin Physician/ 01/01/2012 P_{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Irwin Avenue Elkton Œil If Under 1 Year If Under 24 Hrs. Social Security Numbe last birthday 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Mary Land 1 M 2X F 96 Months Days Hours Min. 217-10-8320 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examinar must hamolitical and injury or other traumatic event; the Medical Examinar must hamolitical and injury or other traumatic event. 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c City, Town or Location EIKton 10d. Inside City Limits Director Cedl MD 1 Yes 2 XNo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21 Irwin Avenue 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. White Specify: 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Agnis Todd Albery Todd 19a. Informant's Name/Relationship (Type, Print)
David Irwin/ Grandson 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 21 Irwin Ave. Elkton, MD 21921 01/06/2012 Cumborland DT 20b. Place of Disposition (Name of cemetery, crematory or other place)
Med Cure Inc. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cumberland, RI 4 XX Sonation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St. Hagerstown, MD 21740 Signature of Funeral Service Licenses M0161 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final HTheroschrosis Physician/ disease or condition resulting in death) 10975 Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or iinjury the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) detached g Unknown ιο τιτe runeral Director; After this certificate has been signed by τ completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending death. 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director; 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 1.3.2012

State

Registrar
DHMH 17 Rev 7/2009

ElhJon MD 21921.

who completed cause of death (Item 23a) (Type, Print

SACHDEN MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner HCaH Hagerstour Washinat CNC Of Haselston If Under 1 Year If Under 24 Hrs. Age (In yrs. last/birthday) 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** ^{Yea}r) 1910 Maryland 1**℃** M 2 🗆 F May Director 214-09-1922 101 Usual Residence of Decedent 28a-f shov 10d Inside City Limits 10b. County 10c. City, Town or Location 10a, State the Maryland notified at Director 1 Yes 2 No MD Hagerstown Washington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or Funeral with U.S.A. 21740 327 South Locust Street Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates er than "natur the Medical I 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cabinetry Cabinet Finisher marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental ပ Harry Hamilton Kretzer Grove Dora and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1313 Cedarwood Drive, Hagerstown, MD 21742 Health a tem 27 i Brian Kretzer / Son item 2 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 injury (Cedar Lawn Mem. Park 1/12/2012 Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel Funeral Service Lice Signatu any 1601 Pennsylvania Ave., Hagerstown, 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (o as a consequence of) Examiner C Securitially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events attending physician and for use as the burial-tra resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t performe 2 No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No death. Accident
Suicide Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 8 201 Name and address of person who completed cause of death (Item 23a) (Type, Pilce Have 14014 31. Date filed (Month, Day, Year) State 1 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Knott 20/d Jean Physician/ Norma Medical a. Facility Name (*if not institution, give street and number)*WM. Regional Medical Center 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Social Security Number 220–26–9773 July 28 1928 Maryland 83 Director 1 M 2X F 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director Westernport notified Allegany MD 28a-f 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò ms 23a or must be r 21562 409 Maryland Ave. United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc ò þ 1 Never Married 2 Married Specify: white Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates "natural" Completed 3X Widowed 4 ☐ Divorced edical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry er than the Me alth and Mental Hygiene.

27 is marked other than
er traumatic event, the Me Elementary/Secondary (0-12) 12 College (1-4 or 5+) Housework Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Wilson Pearl Bray James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
105 Gay St, Westernport, Maryland 21562 19a. Informant's Name/Relationship (Type, Print) Jeannie Pritts/ daughter Department of Health Important: If item 27 any injury or other to once. 20c. Location - City or Town, State
Westernport, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Philos Cemetery 01/12/2012 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licenses plighe 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) to (or as a consequence of)s, Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-trans Due to (or as a consequence of): physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as ding IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year 5 Other (specify) Pregnant at time of death 4 Pregnant : 9 Unknown the a s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s autopsy performed Yes 2 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 No မ 1

Anpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🔲 Yes 2 🗀 No 28d. Describe how injury occurred Certificate: iniury 1 Autural 5 Pending Accident Investigation after death 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled in 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2.

To the F
complet only one

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Blanche Mavromatis, 12500 Willowbrook Road, Cumberland, MD 21502

Registrar's Signature

29d. Date signed (Month, Day, Year) 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 199 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2012^{Year} **Physician** 10:50 PM January 8 Adeline Kendall Knepper /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hagerstown Coffman Nursing Home If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Jan • 11 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) ,1917 **Funeral** 94 Months 1 ☐ M 2 🛛 F Maryland 214-09-0538 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County in than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at 1X Yes 2 No Maryland Washington County Hagerstown Be Completed by Funeral Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zin Code 1013 Potomac Ave. 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hiant: If item 27 is marked oth Clara Bessie Miner Charles Cleveland Kendall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 200 W. Irvin Ave. Hagerstown, MD 21742 Deanna K. Soulis-daughter permit. Pages 1 and Department of Health Important: if item 27 any injury or other tropoce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Smithsubrg Crematory 1-10-2012 Smithsburg, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 (lugles 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dvance Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner transit The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, pe 3 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 2 340 1 Yes 1 ☐ Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner Hospital: Other 1 Inpatient Nursing Home 5 Residence 6 ☐ Other (Specify) 200 2 ER/Outpatient 3 DOA 2 1 Tyes After this funeral 28d. Describe how injury occurred 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 2 □ No 1 Tyes 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

hin 24 hours after death. within 2

> State Registrar

Northern 0 2012

29b. Signature and title of certified

30. Name and address of person who comp

Hagerstown egistrar's Signature

leted cause of death (Item 23a) (Type, Print)

mo

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Roy William Lammers , 2012^{Year} January 9 12:23A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington 21844 Black Rock Lane Hagerstown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. **Funeral** Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Allg. 28, 1918 93 Nebraska Director 482-28-8430 Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Medica Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Washington 1 Yes 2 XNo Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21844 Black Rock Lane 21740 U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify 3 ♥ Widowed 4 □ Divorced White Year or Dates 41 - 45Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Independent Distributor 0il Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chris F. Lammers Dora Klahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a <u>Bonita C. Distad (Daughter)</u> 21844 Black Rock Lane Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory Smithsburg, Md. 21. Signature of Funeral Service Licens 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ aTh disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin physician and s the burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 No signed by the a d be detached f 9 Unknown Part II. Other significant conditions contribut to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A: completed filled in by the f. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of g 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 MD

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day

68760

Box

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) Physician/ Month 1856 M Medical give street and numb 4b. City, Town, or Location of Death 4c. County of Death institution, **Examiner** Coch If Under 24 Hrs. Birthplace (State or Foreign 1 Year 8 Date of Birth **Funeral** Country) WV 1 X M 2 □ F Days Min 3 19 19 7 19 3 7 19 3 7 74 Director 235-54-5076 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at Director 1 🗆 Yes 2 No MD Friendsville Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P Funeral items 23a 627 Blue Goose Road 21531 US. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu N. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🗶 No Specify. white Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) automotive mechanic 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Audrey Faye Thomas Hartsel Scott Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 627 Blue Goose Road, Friendsville, MD. Ardith Lewis 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Shady Grove Cem. 1 Burial 2 Cremation 3 Removal from State 1/9/2012 Bruceton Mills, 4 Donation 5 Other (Specify) Carl R. Spear Funeral Home neral Service Licat 21. Signature Bruceton Mil MA Main St., Approximate Interval Between Onset and Daath that caused the death. Do not enter the mode of dying, such as cardiac or . Enter the disease, or complication shock, or heart failure. List only one caus Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list nonditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det Completed by 2 No 3 Probably 4 hknown 1 Tyes 24b. Were autopsy findings available 24a Was an autopsy performe prior to completion of cause of 1 Tes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 🗆 No Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending work 1 Yes 2 No М Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many er stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year ပ္

DHMH 17 Rev 7/2009

State Registrar 30. Na

Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month: Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner FOR INGTON WASHINGTON 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. **Funeral** Min. 1 M 2 X F Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State **Funeral Director** 1 X Yes 2 No DC. NASHINGTON 10g. Citizen of What Country? 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) MUNITIONS SPECIALIST GOVERNMENT Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ MCLEON 19a. Informant's Name/Relationship (Type, Print)

10A TUAN/TA LINDSAY

61L CHRISHT - DAU 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State E+ LINCOLN -9-2012 BRENTWOOD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Greene Funeral Home IN. Alexandria. VA 22314 ST. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Phy ician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director many others. that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Medical Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1
Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Nurse Practioner to the best of my hope and death occurred at the time, date and due to the cause(s) and manner as stated. (Check 3. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State JAN 0 5 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 25,27,28a-f per me,g924,02/15/2012dhb

Certificate of Death

Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:05pm 03 January 2012 <u>James Andrew LYNN</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Fahrney-Keedy Memorial Home Boonsboro Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 X M 2 🗆 Hours (Month, Day, March I Maryland 91 Director 220-10-3282 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City. Town or Location Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Examiner must be 23a Funeral 525 Rhode Island Avenue 21740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black White, etc. ö þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1942–45 1 ☐ Yes 2 X No Specify: Specify. "natural" Completed 3 Widowed 4 X Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Sheet Metal Worker Aircraft Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Andrew Hugh Lynn Ethel Marie Sprecher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau <u>Tessa Swope –</u> Daughter 525 Rhode Island Avenue, Hagerstown, Md. 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 $\overline{\mathbf{X}}$ Burial 2 \square Cremation 3 \square Removal from State Rocky Gap Vet. Cem. 1/9/2012 Flintstone, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Feral Service License Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ neumon disease or condition resulting in death) Medical Due to or as a consequence of **Examiner** Sequentially list conditions, Examine ATTON APPROVED BY MEDICAL EXAMINER if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 li 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 thknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? Fracture Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) niner? Other: 1 X Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work? 1 \sum Yes 2 \boxed{X} No Natural 5 Pending **4:55 p** м XAccident Subject fell 12/04/2011 Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Town, State) **14014 Marsh Pike** completed filled in by determined Nursing Home Hagerstown, MD 24 hours a Medical 🖟 crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and ma*n*ner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

av

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene	0010	01101.
es McDonald	State of Maryland / Department of Health and Mental Hygiene	2012	01104
4 - 04 4			

Robert James Mo		nald 1- For State Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.									
Physicia Medical Examir	n/	Decedent's Name (First, M	F	Robert	James				2. Date of Dea Month January 9	Day Year 9, 2012	3. Time of Death 1203 hrs	
No. of		4a. Facility Name (if not instit Route 40 East of G	reenbrier Parl	<			b. City, Town, or Boonsboro			4c. County of De Washington		
Funeral Director		5. Social Security Number 214-54-0416	6. Sex		(In yrs. last	birthday) Yrs.	Months Day				Birthplace (State or reign PA	
nd show any cc.		Usual Residence of Deceden 10a. State 10b. Cour Maryland Wo			0c. City, To	wn or Location		gerstow	'n		10d. Inside City Limits 1 Yes 2 No	
th the Maryland 23a or 28a-f show notified at once.	Directo	10e. Street and Number 113 Bethle	ehem Cou	rt			10f. Zip Code	1740		10g. Citizen of What C	-	
ter death wi	Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 X			Navy	lf Ye		n, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	White, etc	nerican Indian, Black, Vhite	
5-0036 led within 72 hours af Hygiene. other than "natural"	Completed by	15. Decedent's Education (S Elementary/Secondary (0-	Specify only highes		leted) 16	a. Decedent	's Usual Occupa est of working life	tion (Give kind		16b. Kind of Busines	ss/Industry	
215-0036 be filed within 77 intal Hygiene riced other than	8	11 17. Father's Name (First, Mid Robert R.	McDonald				Jo	lame (First, Middle,				
MD 21 and 2 should saith and Mer em 27 is man	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Ziper Robert J. McDonald (Son) 484 Round Hill Rd. Winchester, Virginia 2 20c. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town										
Baltimore, permit. Pages 1 ar Department of He. Important: If the		1 Burial 2 Crema 4 Donation 5 Other 21. Signature of Funeral Serv	Specify:	oval from State	Smit	hsbur		$cory \begin{vmatrix} J \\ 1 \end{vmatrix}$	anuary 2, 2012	Smithsb	urg, Maryland	
Physician	4	23a. Part I. Enter the disease	or complications	ViS that caused th	MO 14 1	12.	525 Brac	bury A	ve. Smit		ryland 21783 Approximate Interval	
Vedical Examiner		failure. List only one can Immediate Cause (Final disector condition resulting in death	ase a Contac	t Shotgun r as a conseq		of Head					Between Onset and Death	
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiate events resulting in death) La	o Due to (c	or as a consequer as a conseq								
be execui	la G	UNPENDED	dAMENI							Lood Same date		
Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours af or death. To the Funeral Director After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9	n the 1 4	yes, outcome Live birth Pregnant at tir Unknown		2 Fet	al death 3 er (S <i>pecify</i>)	Ectopic pr	egnancy	23d. Date of delive Month	ery Day Year	
ords, P.O. Bo: w requires that the deat s been signed by the att	2	Part II. Other significant cor	ditions contribu	ting to death b	out not resu	Iting in the u	nderlying cause	given in Part I.	1Ye		robably 4 Unknown	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death. **In Director** After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted.	Completed	Of Wassessells					26 Plane	e of Death (Ch	1 ✓ Yes	psy prior to pringed? death		
of Vital Rec ding Physician: The I harder this certificate I Anter this certificate I	١	25. Was case referred to med examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient		t/Outpatient	3 DOA	Other4 N	ursing Home 5	Residence 6 🗸 Ot	her; Scene	
Sion of Attending F r death. ector After by the funer	Certification:	2 Accident In	ending rvestigation Jar	Date of Injury (Month, Day,Yea UND: 1 9, 2012	r) F:	OUND:		ry at Work? Yes 2 ✓ No	Subject sho		Rural Route Number, City	
Divisior To the Hospital or Attend within 24 hours af or death To the Funeral Director completely filled in by the		4 Homicide 29a. Certifier	Suicide Could not be determined (Specify) Park/Recreation Area or Town, State) Certifier 4 Certified Physicians. To the heat of my knowledge death popured at the time date and place and due to the cause(s) and manner as stated.									
To the Fe within 2. To the Fe complete	Medical	(Check only one) 2 Medical E	xaminer: On the tand mar	pasis of exami nner stated.	nation and/	or investigati	on, in my opinior	n, death occur	red at the time, date	and place, and due to	the cause(s)	
381	-	30. Name and address of per	son who complete	d cause of dea	ath (Item 23	a)	O.C.	M.E.		January 10, 20)12	
Sta		Ana Rubio MD. A	ssistant Med	ical Examinate Registraria			more Street,	Baltimore,	MD 21223			
Registr	ar	JAN TO 20	- Justin	7	(1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 January 2000 Рм Ruth H. Moore Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Laurelwood Care Center E1kton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director Georgia 94 264-03-6164 Usual Residence of Decedent 28a-f show 10a. State 10h. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Funeral 23a 917 North Bridge Street 21921 United States items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō þ 1 Never Married 2 Married hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 'natural", Completed 3 X Widowed 4 Divorced White event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 permit. Page 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Nurses Aid Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mae Bell Norris John Church Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lylis M. Payne/Daughter Bridge Street, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State January 10, 2012 4 Donation 5 Other (Specify) Elkton Cemetery Elkton, MD 22. Name and Address of Facility Hicks Home for Funerals. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

When the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit Exam Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year Pregnant at time of death g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending iniury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and till of certific 29d. Date signed (Month, Day, Year) 1.7.2012 completed cause of death (Item 23a) (Type, Print) ST, Elhan MD 21921

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month January Physician/ 2:12 AM GEORGE THOMAS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, March 9 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 1 🕅 M 2 🗆 F 218-34-3816 **Director** 80 1931 March Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No Maryland Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 311 Broad Street 21769 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces's 1 Never Married 2 X Married Completed by X Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nt of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 8 Farmer Dairy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clarence Mentzer Mazie Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Mentzer - Wife Broad Street, Middletown, Maryland 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Important: I any injury o 4 Donation 5 Other (Specify) Hagerstown Crematory 1/5/2012 Hagerstown, Maryland . Signature de l'ervice Licensee Name and Address of Facility Minnich Funeral Home Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Sevue Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate
Enter Linder ying
Cause (Disease or iinjury Due to (or as a consequence of): burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Yes 2 No ed by the a 9 Unknown g 🗌 Unknown P.O. 1 signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 🖺 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sis completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 📑 No မ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred ☐ Natural iniury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical *Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

JW.5

State Registrar

only one

29b. Signature and title of certifie

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

re Ave Frederick

12

12-00204	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	201	2	01	1 6
Charles E. McGuinness	State of Maryland / Department of Health and Mental Hygiene	201	4	Ul	1 (
1. For State	0.17. 1.15. 11				

	1- For State Certificate of Death Reg. No.											
Physic	Decedent's Name (First, Midd					Date of Death Month Day Year		3. Time of Death				
Vledical Exam	iner	Charles Edward McGuinness 4a. Facility Name (if not institution, give street and number)			La	I	F (D 1)	January 7	, 2012	1359 nrs		
		25801 Shady Lane	on, give street and n	umber)		. City, Town, or Lo Westernport	ocation of Death		4c. County of Allegany			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last bi		If Under 1 Year	If Under 24Hrs.	8. Date of Bir		9. Birthplace (State or		
Director		218-60-0314	1XM 2 F	59	Yrs.	Months Days	Hours Min.	1	26,1952	Foreign		
		Usual Residence of Decedent	164 26		110.			Abrit	20,1902	, Keysel, wv		
r any		10a. State 10b. County		10c. City, Tow	n or Location	n				10d. Inside City Limits		
Maryland 28a-f show d at once.	ō	MD A1	legany	Wes	ternp	ort				1 Yes 2 No		
Maryl 28a-	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wh	at Country?		
with the Maryland ms 23a or 28a-f sho be notified at once.	io i				21562				USA			
th wit	Funeral	11. Marital Status 1 Never Married 2 M		cedent Ever in U.S. orces?		Decedent of Hispa s, specify Cuban, I			14. Race White	- American Indian, Black, . etc.		
er death , or ite	Ī		1 Yes	2 X No								
irs aft iural"	by	15. Decedent's Education (Spe	or Dates:			es 2 X No		ork done	Specify: 16b. Kind of Bus	White siness/Industry		
72 hours after death with the Maryland n'antural", or items 23a or 28a-f she al. Eximiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (st of working life. D				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
036 ithin 72 ne. r than	μ	12			Delivery Driver				Bakery .			
215-0036 be filed within ntal Hygiene. rked other tha ent, the Medis												
21215-0036 21215-0036 suld be filed within 72 Mental Hygiene. marked other than 'ic event, the Medical	Be											
D 21 should and Mer	2	(chock and Manipoli of Material College Lip Golde)										
imore, MD 2 Pages 1 and 2 shoul ment of Health and N taut: If item 27 is m or other traumatic.		Kimberly S. J 20a. Method of Disposition	ames/Daug			ichard A		Harris Date	on, OH	43103 City or Town, State		
IOFE ges 1 it of H i: If i		1 X Burial 2 Cremation		rom State crema	atory or othe	r place)	Jar	1. 13				
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Sp 21. Signature of Funeral Service		Cherr		1 Cemete me and Address o	C.F 100	2012		Tract, WV		
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		PSILOU	IS.	46		S. Main	Smi		eral Hom	e 26726		
Physician		23a. Part I. Enter the disease, or	complications that of	aused the death. Do r	not enter the	mode of dying, su	uch as cardiac or	respiratory arr	est, shock, or hea	rt Approximate Interval		
/Medical £xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Fentanyl Intoxication Between Onset and Death										
_Adminici		or condition resulting in death)		a consequence of):								
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
	Ē	cause. Enter Underlying Cause (Disease or injury that initiated										
ed nsit	Examiner	events resulting in death) Last	Due to (or as a	a consequence of):):							
760, Trate be executed physician and the burial - transit		X UNPENDED 23a,27,28a-f,per me,g924 2-13-12 sm										
8760, tificate being physicias the buris	Jed Jed	IF FEMALE:		outcome of pregnancy					23d. Date of	delivery		
5876 artificate ling phy	an/	23b. Was decedent pregnant in the past 12 months?	pirth	2 Fetal death 3 Ectopic pregnancy				Month Day Year				
OX (sath ce	With the past 12 months? AMENDED 23a, 27, 28a-f, per me, g924 2-13-12 sm AMENDED 23a, 27, 28a-f, per me, g924 2-13-12 sm AMENDED 23a, 27, 28a-f, per me, g924 2-13-12 sm AMENDED 23a, 27, 28a-f, per me, g924 2-13-12 sm IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contributing											
). BC the degraph of the degraph of	F			Unknown Intributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?			
s, P.C. nires that the signed by t	<u>a</u>	1 Yes 2 ✔ No 3 P										
ds, equire een si ould b	ompleted	24a. Was an 24b. V							Vere autopsy findings available			
Records, The law requir ficate has been s	힅							autopsy prior to completion of cause of death?				
tal Rec cian: The l certificate !	ပေျ	25. Was case referred to medica				26 Pleas at	f Dooth (Charles	1 Yes	2 No 1	Yes 2 No		
Vital bysician:	Be	examiner? Hospital: Hospital: Office Offic										
1 of Vital ling Physician: After this certi funeral director	27 Manner of Death 28a Date of Injury 28b Time of Injury 29c Injury of World								28d. Describe how injury осситеd			
ion tendin eath. tor: A	tion:	1 Natural 5 Pend 2 X Accident Inves	ling £3 1		1:00	1 Yes		subject medicat		prescription		
Division tal or Attendii rs after death. al Director: A	j <u>i</u>	2 X Accident Investigation 1 Could not be 1 Could not be 1 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rt. 28f. Location (Street and Number or Rt.										
Divisospital or Anthons after meral Directly filled in b	Certificati	4 Homicide determined (Specify) Residence apt #214 Westernpo								rnport.Md.		
Division of Vital Records, P.C. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To tl withi To tl	Medical	2	and manner s		investigation	29c. License r		the time, date		d (Month, Day, Year)		
		A neh	1 0/ 1			O.C.M.			January 8, 2			
1		30. Name and address of person	Who completed	so of death /Itam 33-1		0.0.1	. .					
4		Pamela E. Southall, N		se or death (item 23a) Medical Examine		W. Baltimore	Street, Baltin	nore, MD 2	1223			
S	ate	31. Date filed (Month, Day Year)	32. Re	egistrar's Signature	1.1							
Regis	trar	JAN 1 9 2012	Clever	A. Jan								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edward Allen May 5:59 P M 2012 Januarv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 311 Greene Street, Apt 3 Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 💢 M 2 🗆 F 61 Director 173-42-5965 12/04/1950 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important, or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 20 or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic avent, the Medical Examiner must be notified at once. Director 1 X Yes 2 No MD Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 311 Greene Street, Apt 3 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Manager Automobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Мау Virginia Mae Oscar Olin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 Royal Manor Dr, Apt 302, Allison Park, PA15101 Shanin R. May-Markl / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗌 Cremation 3 🔲 Removal from State Glendale Cemetery 01/12/2012 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service L 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 Part T. Exter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between ACUTE Onset and Death Immediate Cause (Final Provoician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SYMPATHEIL DYSMUPHY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s performe Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🔲 Yes 2 🔲 No 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) FLLI-D0034812 January 9, 2012 3+ 30. Name and Again.
Eugene dress of person who completed cause of death (Item 23a) (Type, Print) ene Nallin, M.D., 909B Seton Drive, Cumberland, Maryland

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-00031 Gilbert Eugene Myers State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death **Medical Examiner MYERS** 2127 hrs GILBERT EUGENE January 1, 2012 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Baltimore County** 731 Holly Road Essex 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Months Days Hours Director 03/31/1932 216-30-5993 79 1 X M 2 F Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 X No MD BALTIMORE Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21221 731 HOLLY ROAD Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 | Married 2 X No 1 | Yes \mathtt{WHITE} 4 X Divorced f Yes, Give Yee 1 Yes 2 X No specify: Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) STEEL MD 21215-0036 ELECTRICIAN 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) BERTHA LORENA SIMPSON partment of Health and Mental F portant: If item 27 is marked ury or other traumatic event, i Be EUGENE GEORGE MYERS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13000 EASTERN AVENUE, BALTIMORE, MD PATRICIA HAAS / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State FORT ASHBY, WV 01/07/2012 FORT ASHBY CEMETERY 4 Donation 5 Other Specify 22. Name and Address of Facility UPCHURCH FUNERAL P.O. BOX 1260, FORT ASHBY, WV 21. Şignature of Funeral Service Licenses 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death a. Contact Shotgun Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or es a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit Physician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of After this certificate has performed? ✓ Yes 2 No 2 No 1 🗸 Yes ospital or Attending Physician: hours after death funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 2 28a. Date of Injury FOUND: Day,Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject shot self FOUND: 1 Natural 1 Yes 2 ✔ No Pending the the To the Funeral Director: Jan 1, 2012 2 Accident 2112 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 731 Holly Road, Essex, MD determined (Specify) Yard Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 2, 2012

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Jack Titus MD.

31. Date filed (Month, Day, Year) JAN 0 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Date of Death Time of Death Physician/ 880 B MOORE AMES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Seasons Hospice <u>Randallstown</u> <u>Baltimore</u> 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days 241-56-1112 1 ₹ M 2 □ F **Director** 70 1-11-1941 NC Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at Director MD Prince George's Capitol Heights 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 202 Daimler Drive 20743 items 2 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural" 3 Widowed 4 X Divorced B1ack Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) 11th College (1-4 or 5+) Private Clothing Designer should be filed with and Mental Hygien Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Love Moore Sr. Margaret Hinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Douglas Moore/Son 3103 Orleans Ave, District Heights, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 1-14-2012 Laurel, MD 4 Donation 5 Other (Specify) Maryland National 22. Name and Address of Facilit Pope Funeral Homes, F.A. 21. Signature of Funeral Service Lice 5538 Marlboro Pike, Forestville, MD 20747 wxo Molas nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Inter the disease, or complications the shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final Physician TA7 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No detached the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work's within 24 hours after death.

To the Funeral Director; A completely filled in by the fi 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical 29a. Certifier critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and tole of certifie Registrar

DHMH 17 Rev 06-2011

4	2	\sim	20		0
-1	/-	u	าด	כיו	ο .

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rnest Clifford Na		rod St I- For Stata	ate of Maryla		artme e <i>rtifica</i>			Menta	al Hy		eg. No.	201	2 0111		
Physiciar		Registrar 1. Decedent's Name (First, Middl	e,Last)		-				- 12	2. Date of Dea Month	th	Year	3. Time of Death		
ledical Examin	er	Ernest Cliffor								January 2		2	2122 hrs		
10		4a Facility Name (if not institutio 61 Blaines Way	n, give street and nu	umber)		4	b. City, Town, or L Friendsville	ocation of	Death			c. County of Deat Garrett	h		
Funeral	4	5. Social Security Number	6. Sex	7. Age (In yrs.	. last birtho	day)	If Under 1 Year	If Under	24Hrs.	8. Date of Bi	rth (MM	I/DD/YYYY) 9. Bi			
Director	-	219-76-4384	1 X M 2 F		48	Yrs.	Months Days	Hours	Min.	June 2	20,	1963 Forei	^{gn} ^{puntry)} Maryland		
	ŀ	Usual Residence of Decedent	1 2		10					100					
' any	Ī	10a. State 10b. County		10c. Cit	ty, Town o	r Locatio	on						10d. Inside City Limits 1 Yes 2 X No		
aryland 8a-f show at once.	5	MD Garre	tt	Fr	iends	vil									
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number					10f. Žip Code 21531				US US	tizen of What Cou !∆	into y ?		
ith the 23a o notifi													rican Indian, Black,		
eath w	a	1 Never Married 2 X M	arried Armed F		0.0.		es, specify Cuban,					White, etc.			
after d	고									Specify: White					
nours a	eted b	15. Decedent's Education (Spe	cify only highest gra				's Usual Occupations of working life.				16b.	Kind of Business	/Industry		
36 in 72 i		Elementary/Secondary (0-12)	College (1-4 or 5+)	Sto	ne i	Mason				Bı	nildina (Construction		
d with giene	Comp	17. Father's Name (First, Middle	Last)		Dec	/IC I		8.Mother's	Name ((First, Middle,					
21215-0036 Ald be filed within 7 Mental Hygiene. The recent the Medica	Be	Ernest Warner	Nazelrod							Annette					
hould hould is man	₽[19a. Informant's Name/Relations					Address (Street								
MD and 2 sho saith and 2 is reumati	F	Michael J. Naz	ercod/Sor				aines Way		тепс	Date		Location - City o			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	-	1 Burial 2 X Cremation	n 3 Removal f	rom State			er place)	tor	Tar	1. 2	h12	Davides	ville, PA		
it. Paurtmen	}	4 Donation 5 Other Si 21. Signature of Funeral Service	becify:	100	Juille		ame and Address								
Depa Imju		D. Level Jew	man				O. Box 2						5		
Physician	T	23a. Part I Enter the disease, or failure. List only one cause	complications that on each line. Ca	aused the dea	th. Do not	enter th	e mode of dying.	such as ca ated	rdiac or	respiratory ar h Card	rest, sh LOM (nock, or heart egaly	Approximate Interval Between Onset and		
Medical Examiner	1	Immediate Cause (Final disease	a and Bi	ventric	ular	Di1	atation						Death		
	-	or condition resulting in death)	Due to (or as	a consequence	e of):								9		
	힐	Sequentially list conditions, if any, leading to immediate		a consequence	r of).										
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence	e of):										
O, be executed sician and burial - transit		events resulting in deathy Last	d.												
e exection and initial - t	gica	X UNPENDED	AMENDED	23a,27	,per	me,	g924 2-8	-12 s	SM						
lox 68760, eath certificate be attending physici for use as the buri	w F	IF FEMALE: 23b. Was decedent pregnant in t		outcome of pre	egnancy		al death 3	Ectopic	nrennar	ncv	2:	3d. Date of delive Month	ry Day Year		
x 68 h certif tending use as	Physician/M	past 12 months?	4 Preg	nant at time of	death 5	=	ner (Specify)		progridi						
Box e death c the attented for us	Jys.		known 9 Unkr							Dan Did	tahaaa	o uso contributo t	o the cause of death?		
	و م	Part II. Other significant condit	tions contributing	to death but no	it resulting	in the u	nderlying cause g	iven in Par	τ Ι.				obably 4 🗸 Unknown		
ords, I										24a. Was			autopsy findings available		
COF law rate has bee 2 sho	Completed									auto perfe	ormed?	death?			
tal Rec		25. Was case referred to medica					26.Place	of Death (Check c			140	165 2 160		
Vital hysician: hysician: this certifi	e B	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Ou	tpatient	3 DOA	Other ₄	Nursing	g Home 5	Resid	dence 6 🗸 Oth	er: Scene		
ding Phy		27. Manner of Death	28a. Date (Mont	e of Injury th, Day,Year)	28b. T	ime of Ir		y at Work?		28d. Describe	how ir	njury occurred			
ision of Vital Attending Physician: Ar death. rector: After this certifi	atio		ding stigation					es 2		201 1 1	(0)	and M. Indiana and F	and Davide Mambae City		
Division of Vital Records, pital or Attending Physician: The law requirement after death. In the certificate has been stilled in by the funeral director, page 2 should	Certification:	dete	ld not be 28e. Pla (Specify		t home, far	rm, stree	et, factory, office b	uilding, etc	3.	or Town,		and Number of F	Rural Route Number, City		
hou y fil		4 Homicide 29a. Certifier	hysician: To the be		edge, dea	th occur	red at the time, da	te and pla	ce, and	due to the cau	use(s) a	and manner as st	ated.		
Division To the Hospital or Attenwithin 24 hours after death To the Fineral Director: completely filled in by the	Medical	(Check only one) 2 ✓ Medical Exa	miner: On the basis	of examination	n and/or in	vestigat	ion, in my opinion	death occ	curred a	t the time, date	e and p	place, and due to	the cause(s)		
F. 2 5 8	¥	29b. Signature and title of certifi	er		1		29c. Licenso					d. Date signed (M			
		6-111	11	1	1	_	O.C.1	И.E.			Ja	nuary 3, 201:	<u> </u>		
			who completed car Assistant Medi) W F	altimore Stre	et Baltir	more	MD 21223					
- C4-		Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year,		Registrar's Sign		. vv. C		or, Darth	, 510,						
Registr		JAN - 6 20	140	A	. 1	.0.	-3.00								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Pauline Anna Ohmart January 2012 2:48 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot William Hill Manor

5. Social Security Number 6. Sex Easton
If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Year) **Funeral** Days Months Hours 1□ M 2🕱 F 0k1ahoma April 19, 1908 Director 441-40-2364 103 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Its Modical Evaning nust be rediffied at 1 XYes 2 □ No Director Maryland Talbot Easton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21601 209 Davis Avenue Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □**X**No Specify. ģ 3 N Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Schoo<u>l teacher</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be Health and Mental em 27 is marked o Thaddeus McKelvey Cowan Christine Anna Thompson ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Easton, Maryland 21601 209 Davis Avenue Pages 1 and Sandra Tyrer/daughter permit. Pages 1 an Department of Heal Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Enid, Oklahoma 1/28/2012 4 □ Donation 5 □ Other (Specify) Memorial Park Cemetery 22. Name and Address of Facility Moore Funeral Home, P.A. 21. Signature of Funeral Service Licens Denton, Maryland 21629 12 South Second Street 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** ASPIRATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner WEEKS YSPHAGIA Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No P.O. 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ∐Yes 2 🗷 No Division of Vital funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Hospital or Attending 1 Natural
2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

Registrar

31. Date filed (Month, Day,

JAN @ 9 20

DHMH 17 Rev 1/2001

MD 321 BLOOMING DALL

ATTENDING MD person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

00053094

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2012 JANUARY 03:00 PM MARYLEE OWENS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner CECIL 101 MILL LANE NORTH EAST 9. Birthplace (State or Foreign . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Year) 939 Month, Day, 1 🗆 M 2 🗶 F Months Hours MARYLAND Director 72 219-34-2236 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1xXYes 2 □ No MARYLAND CECIL NORTH EAST 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral or items 23a 21901 UNITED STATES 101 MILL LANE death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 72 hours after WHITE 1 Yes 2 XXNo Specify If Yes Give "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72.1 and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BERTHA HEVERIN CHARLES D. PALMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health ar ant: If item 27 is MILL LANE, NORTH EAST. MARYLAND J. OWENS, SR. / SPOUSE SAMUEL 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1xxBurial 2 Cremation 3 Removal from State NORTHEREASTONINTTERSE
METHODIST CEMETERY JANUARY 5, any injury or NORTH EAST, MARYLAND Important: 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 21. Signature of For era Sarine Licensee 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure, List only one cause on Immediate Cause (Final Physician/ years disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or iinjury and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death signed by the a 1 ☐ Yes 2 E q | Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b page 2 s autopsy performed? death? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d Describe how injury occurred iniury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one 1.3.2012.

State Registrar

DHMH 17 Rev 7/2009

eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201^{Year} Gladys Christine Pinder January 1824 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rising Sun Cecil Calvert Manor Healthcare Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 6. Sex Months Days 1 🗆 M 2 💢 F Min OCT 13. Year) West Virginia Director 236-20-1697 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 United States 182 Woods Way within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: Completed 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within. Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) In Her Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arlie W. Wade Nellie Mae Hennen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bessie Bamberger/Daughter 176 Gallaher Road, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gifpin Manor Memorial Park X Burial 2 Cremation 3 Removal from State January 4 ☐ Donation 5 ☐ Other (Specify) 2012 Elkton. MD 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic morani disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires JEDINESSION 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate | 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 17002832

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

State Registrar

DHMH 17 Rev 7/2009

Way, Rising

101 COLOVIAL

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MLA

LATTIN.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2012^{Year} 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Garrett Garrett County Memorial Hospital Oakland 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F NOV. IS, Months Days Hours Min. 215-16-6542 1920 Maryland Director 91 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Grantsville MD Garrett 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21536 USA 175 Meadowview Dr. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces? 1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Midowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2+ Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ellen Elizabeth Hill Wallace Bruce LaCrosse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Taliaferro/Son P.O. Box 13, McHenry, MD 21541 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Country Side Crematory Jan. 9, 2012 Davidsville, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee X P.O. Box 275, Grantsville, MD 23a. Part 1. Ent-ir t e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval etween et d Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1. Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

Box 68760 To the Hospital or Attending Physician: The law requires that the a within 24 hours after death.

To the Funeral Director, After this cartificate has been signed by the completed filled in by the funeral director, page 2 should be detached. <u>P</u> Records, Division of Vital

> State Registrar

29a. Certifier

(Check

Robert

29b. Signature and title

Α.

31. Date filed (Month, Day, Year) **JAN 1** 0 2012

Goralski,

DHMH 17 Rev 7/2009

inpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

311 N. Fourth St.,

Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Pragrener: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D23979

Oakland, MD

21550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year 9:37 A Palmer Donald Eugene January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany LaVale 12711 Gramlich Road, SW Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 1 🛛 M 2 🗆 F Days Hours Min 87 Yrs. **Director** 204-14-0387 06/01/1924 Pennsylvania Usual Residence of Decedent 28a-f shov ä 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 ☐ Yes 2 X No LaVale MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21502 USA 12711 Gramlich Road, SW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. q 1 Never Married 2 Married 1 X Yes If Yes, Give Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify Specify. "natural", 3 X Widowed 4 □ Divorced Completed White Year or Dates mit. Page 1 and 2 should be filed within 72 hour bartment of Health and Mental Hygene. ordant. If item 27 is marked other than "natur injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Foreman Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nell Smith Alberta Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 6206 Appletown Road, Boonsboro, MD Carol D. Wilt/ Daughter Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State MD Vet Cem @ Rocky Gap 01/07/2012 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mams Family Funeral Mome, F.A. 21. Sign ture of Funeral Service Li 404 Decatur Street, Cumberland, MD 21502 Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a chiline. Approximate Interval Between Onset and Death 23a, Part Immediate Cause (Final Physician/ nouk disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exami Hospital or Attending Physician: The law requires that the death certificate be executed and-tran Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ____ Pregnant at time of death the 9 Unknown 9 Unknown Division of Vital Records, P.O. by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of 24a. Was an has s autopsy page death? this certificate 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to redical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: As completed filled in by the fu 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Pragitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number D22181 January 3, 2012 5+

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who complete

31. Date filed (Month, Day, Year)

Gary L. Wagoner, M.D.,

2012

Carla.

925 Bishop Walsh Road, Cumberland, MD

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JAN. 11, 2012 **Physician** 6:10P M JAMES FRANKLIN RILEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GENESIS LA CHARLES PLATA CENTER If Under 1 Year Birthplace (State or Foreign Country) yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 XM 2□ F 236-66-7628 69 KY. 1-10-1943 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 ☐Yes 2 No ed other than "natural", or items 23a or 28a-f slevent, the Wedical Examination of the motified Director WALDORF MD. CHARLES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2687 ST.PETRE'S CHURCH ROAD 20601 U.S.A. Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 25 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No SpecifyWHITE þ 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) WSSC CREW SUPERVISOR 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAMES FRANKLIN RILEY, SR. EMMA MAY MILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) es 1 and 2 of Health a 8660 VALLEY DRIVE WALDORF, MD. 20603 SHARON MIDDLETON-COMPANION 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages . permit. Pages Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ST. PETER'S CEM. 1-18-12 WALDORF, MD. 2. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Euneral Service Licensee M00479 LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician motostotic resulting in death) /Medical Due to (or as a consequence of) Examiner AIR WILL Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) O. Box 68760 Physician/Medical signed by the attending place as be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed' 1 ☐Yes 2 ☑No 2 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) **2√**1N₀ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation t√Natural death. 1 □Yes 2 □No n 24 hours after death.

e Funeral Director: A letely filled in by the fi 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only within 2. and manner stated. 29b. Signature and title of certifier 29d. Date signed, (Month, Day, Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ridge Physician/ JAN. 8, 2012 Barbara 8:20A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** LA PLATA CHARLES CHARLES CO.NURS.& REHAB.CENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Min 2-23-1933 WASH.,D.C. 578-44-6375 1 □ M 2**X** F Director 78 Usual Residence of Decedent or 28a-f show 10d Inside City Limits death with the Maryland 10a. State 10b. County 10c. City. Town or Location Director notified MD. CHARLES LA PLATA 1 X Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? must be r Funeral 104 DON SINSEL COURT 20646 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ral", or iter Examiner Armed Force Black White etc by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give X Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify.WHITE "natural", 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MARRIOTT CORP. CASHIER 12th Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental item 27 is marked c ည MOODY HENRY SANDERS LUCILLE SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOBBIE HOGLUND-DAUGHTER 104 DON SINSEL CT. LA PLATA, MD. 20646 other 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of F Important: If ite any injury or other 1 Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GREENLAWN MEM.GARDENS 1-13-12 CHESAPEAKE, VA. 21. Signature of Funeral Service Licensee M00479 Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A.

LA PLATA, MARYLAND 20646

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Atrial Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical nsequence of): Due to (or as Examiner smo navy Sequentially list conditions. Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician Be Completed by Physician/Medical requires that the death certificate be IF FEMALE: completely filled in by the funeral director, page 2 should be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Parleinson diseane, Anxiety 1 Yes 2 No 3 Probably 4 Unknown Records, Chronic andemia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 유 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After iniury work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 071199 01101 30 Name and address of person who completed bause of death (Item 23a) (Type, Print) on Blvd Swith B. Gilen Bus nie, MD, 21061 32. Registrar's signatur

DHMH 17 Rev 06-2011

State Registrar

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Carey REEVE, SR. Day 2012 Year January 11:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Washington **Examiner** 931 Spruce Street Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** Aug. Tr. 1 X M 2 | F Months Days Hours Maryland 218-10-7010 56 1955 Director Usual Residence of Decedent 28a-f shov 10b. County er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Hagerstown Maryland Washington Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 931 Spruce Street U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 K Married Yes 2 X No Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) mechanic auto Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dawn Elizabeth Angevine Donald Hathaway Reeve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LuBeth Reeve - wife 931 Spruce Street, Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State January 9,2012 Hagerstown Crematory Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ CIERHOSIS ALCOHOLIC YEARS Medical resulting in death) Due to (or as a consequence of) Examiner YEARS ALCOHOL DEPENDENCE Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami Hospital or Attending Physician: The law requires that the death certificate be executed trar Due to (or as a consequence of) attending physician for use as the burial Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Physician, 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death Unknown signed I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> HYPERTELYNON 1 Yes 2 No 3 Probably 4 Unknown Completed plnods peen CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed Yes 2 this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural 5 \square Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) 058810 YAMUREY MD on who completed cause of death (Item 23a) (Type, Print) JW-10 12916 CONAMAR DRIVE. SUITE 204 HAGERSTOWN 31. Date filed (Month, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	ryland				l Mentai Hy	giene 2	012	01120
			Registrar 1. Decedent's Name (First, Middle, La	ast)		Cer	tificate of L)eath	2. Date of De	Reg. No.	012	3. Time of Death
	ysicia		Claude 1	2ay					Janua 14	Day 03	2012	09 39 AM
	Medic xamin		4a. Facility Name (if not institution, giv	e street and number)			4b. City, Town, or	Location of Dea		4o. Coun	ty of Death	
nort .			Northwest to					Istour			timo	
	neral ector		5. Social Security Number 6. 217–94–0405	Sex 7. Age of the first of the	In yrs. Ia 46	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Min	n. (Month, Da	ay, Year)	Counti	lace (State or Foreign ry)
			Usual Residence of Decedent						NOV 30	1965	I NORT	H CAROLINA
ryland	ed at	ctor	10a. State 10b. County		10c. City	, Town or Lo					10	Od. Inside City Limits
le Mai	notifi	Dire	MARYLAND HARF 10e. Street and Number	ORD			HAVRE D	E GRACE		10g. Citizen of	What Count	1 X Yes 2 □ No
with th	st be	Funeral Director	850 ERIE STREE	T				21078		_	TED S	
death	nems ner m	F	11. Marital Status	12. Was Decedent Event Armed Forces?	er in U.S	. 13. V	Vas Decedent of H	ispanic Origin? (In. Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Ra	ice - America ack, White, e	
after a	xamir xamir	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🂢 Divorced	1 ☐ Yes 2 🔀 N If Yes, Give	0	- 1	☐ Yes 2【 No		,		y: BLA	
2-0030	lical E	lete	15. Decedent's		1		lent's Usual Occup			16b. Kind of	Business Ind	ustry
172 nin 72 ne.	e Mec	Completed	(Specify only highest of Elementary/Seconday (0-12)	rade completed) College (1-4 or 5+)		Ìife. D	kind of work done of NOT use retired)	during most of w	orking	00		CHITCH
ad with	ant, the	a)	12 17. Father's Name (First, Middle, Last,				FLAGMAN	19 Mother's N	lame (First, Middle,	1	NSTRU	CTION
Yland Id be filed Mental Hy	tic eve	힏	CHARLIE PAUL M						CE YVONNE			
Waryland 21215-0036 2 should be filed within 72 hours after death with the Maryland in and Mental Hygiene.	iten z/ is marked other than "natural", or items zoa or zoa-i snow other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship						Rural Route Numbe			ode)
and 2 s Health	ther tr		CLAUDETTE M. RAY 20a. Method of Disposition	(SISTER)	ook Di			ET, ABEI	RDEEN, MA			Chata
pairin Page 1 a Department of P	yoro		1 ☐ Burial 2 🏋 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	ce	metery, cren	sition (Name of natory or other place CREMATOR		Date /10/12	20c. Location		
baltimor permit. Page 1 Department of	injur l	1	21. Signature of Funeral Service Lice		מות	22	. Name and Addres	ss of Facility				IE, MD
	any ir once.		Pasa Sa	tt- Col	nes				RAL HOME, L. HAVRE		E, MD	21078
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused to one cause on each line.	he death	. Do not ente	r the mode of dyin	g, such as cardi	ac or respiratory ar	rrest,		Approximate Interval Between Onset and Death
Physi Me	cian/ dical	ı	Immediate Cause (Final disease or condition resulting in death)	a. Due to for so of	S	2000 001					-	Onser and Death
	niner			Due to (or as a d	conseque	ence or):						
_	#	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a o	conseque	ence of):						
ecuted	trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	conseque	ence of):						
be ex	for use as the burial-transit		rooding in dodn'y 235t	■ d	, , ,							
oo/o ertificate ding phy	as the	sician/Medical	IF FEMALE:	_ u		_						
th cert	or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	☐ Fetal	death 3		:y			ate of delive	ry Day Year
• DOX ne death of the atter	ched f	Physic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	ime of de	eath 5 L	Other (specify)					Day roan
that ti	e deta	by P	Part II. Other significant conditions	contributing to death but	not resu	lting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use cor	ntribute to the	e cause of death?
aw requires	d bluc								_ 1 🗆	Yes 2 No	3 🗌 Prob	ably 1/1 Unknown
law re	e 2 sh	Completed	*						24a, Was auto	psy	prior to con	sy findings available npletion of cause of
The Tre	lirector, page 2	_	25. Was case referred to medical	1					1 Tes	2 No	death?	2 15 No.
siciar s certif	lirecto	To Be	examiner? 1 D Yes 2 D No	Hospital:	+ 21/1	ER/Outpatien	Oth	er:	neck only one) 1 Home 5 □ Resi	danaa 6 🗆 Ot	har (Chaoifd	
og Phy	neral		27. Mannyr of Death	28a. Date of injury (Month, Day,	1:	28b. Time of injury	28c. Injury	/ at		now injury occur		-
Attendir r death.	the fu	Certificate:	1 Natural 5 Pending 2 Accident Investigativ 3 Suicide 6 Could not	on he			M 1 🗆	Yes 2 No				
l or At after of Direct	l in by		4 Homicide determined		- At hor (Specify)	ne, farm, stre	et, factory, office		28f. Location (City or Tov	Street and Num vn, State)	ber or Rural I	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and	d fillec	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best of m	y knowle	dge, death o	ccured at the time	, date and place	, and due to the ca	nuse(s) and man	ner as stated	d.
the Hi hin 24	mplete		only one) 3 Certifying Nu	niner: On the basis of exa rse Practioner: To the be			eath occurred at the	e time, date and		e cause(s) and r	nanner as sta	ted.
P Vit	8		29b. Signatur fandstitle of certifier	11			29c. License			29d. Date sign	ed (Month, D	ay, Year)
	2	ł	30. Name and address of person who	completed cause of dea	th (Item:	23a) (Tvne. P		02650		Januar	14,2	01/
)_		Tanvell Gails 50	101 oldrown	100	o ran	elalis town	MD	21133			
Re	State gistra	e r	31. Date filed (Month, Day, Year) JAN 0 6 2012	32. Registrar's	Signatu	barke	1					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician A^{M} January 4, 2012 7:45 <u>Ora Elizabeth Redden</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Envoy of Denton Denton If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛣 F Director 99 November 3, 1912 Maryland 217-28-4470 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Caroline Ridgely Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 303 Park Avenue 21660 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **X**No altimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify. þ 3 □ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "ny Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Richardson <u>Providence</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau
once. Denton, Maryland 21629 E. Marvin Redden/Son 8566 Dogwood Blossom Lane 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Denton Cemetery 1/7/2012 Denton, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street Denton, Maryland 21629 Part1. Enter the diseas shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** €49 Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 mont Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 Yes 2 ► NO After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural Injury n 24 hours after death.

In Funeral Director: Af sletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24

Registrar

Wollings 31. Date filed (Month, Day, Year)

JAN @ 6 2012

29b. Signature and title of certifier

3683 Chaptenk Rd 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bitter

ann

29c. License number

00023722

Preston

29d. Date signed (Month, Day, Year)

2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HARAR Mont O (2215 M TARRU O 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANDARIN HOSPICE HOUSE HARWOOD ANNE ARUNDEL 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Country) **Director** 1 M 2 D F 577-24-0776 88 Yrs 8-31-1923 PA. ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD. CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 2382 PADDINGTON COURT 20602 U.S.A death v 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Yes 2 □ No USAF
If Yes, Give
Year or DatRET 21 yrs Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 9 1 Never Married 2 X Married 72 hours after Maryland 21215-0036 1 Yes 2 No Specify Specify:WHITE "natural", 3 🗌 Widowed 4 🗎 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) RET.STAFF SGT. U.S.A.F. 12th marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HARRY GURNARD SHARAR METTA MARIE HUFF injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is n S PATRICIA SHARAR-SPOUSE 2382 PADDINGTON CT. WALDORF, MD. 20602 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 1-17+12 CLINTON, MD. . Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MANTLE COL 4MPHOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a conse juence of Exami The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burial physician at the burial Physician/Medical Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Day Year Pregnant at time of death 5 Other (specify) g Unknown g Unknown P.O. been signed by the should be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an s certificate has t director, page 2 s prior to completion of cause of death? performe 1 Yes 2 No Division of Vital the Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence eral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To 29b. Signature and title of certific

State Registrar ame and address of persol

31. Date filed (Month, Day,

DHMH 17 Rev 06-2011

completed cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month J AN Physician/ 11:53 SPICKLER 6 RICHARD 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLHUD MEDICAL CENTA BALTIMOR 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months Days 4/29/1942 Year) WEST VIRGINIA 69 **Director** 233-60-2913 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director MARTINSBURG BERKELEY W٧ 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 25404 USA 38 PHYLLIS DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedon. _ Armed Forces? 1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry AUTOMOBILE SERVICE al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) STATION OWNER/OPERATOR 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F is marked of CHESTER LEROY SPICKLER EDNA HAREFORD ပ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
38 PHYLLIS DRIVE, MARTINSBURG, WV 25404 19a. Informant's Name/Relationship (Type, Print) ge 1 and 2 s t of Health a If item 27 i MARSHA SPICKLER/SPOUSE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page 1 Department of Important: If ii any injury or o 2012 MARTINSBURG, WV 4 ☐ Donation 5 ☐ Other (Specify) ROSEDALE CEMETERY 21. Signature of Funeral Service Licenses BROWN FUNERAL HOME, PO BOX 821, 22. Name and Address of Facility P 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HEMOREH AGE ABDOMINAL disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner METABOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of) Physician/Medical P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> RIGHT LUNG TRANSPLANT, CHRONIC OBSTRUCTIVE 1 XYes 2 □ No 3 □ Probably 4 □ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an PULMONARY DISEASE ACUTE KIDNEY INJURY autopsy death? 1 ☐ Yes 2 No hours after death.

Ineral Director: After this certific of filled in by the funeral director, 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Certificate; To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending work? 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I completed filled Medical tule of this physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JAN 4, 2012 R133788 nen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. GREENE STREET, BALTIMORE MARYLAND OTREMBA 31. Date filed (Month, Day, 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of De 2. Date of Death Decedent's Name (First, Middle, Last) Day 2012 7:00 AM Physician/ Elizabeth Anthony Saunders January Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Mitchellville Collington Episcopal Nursing Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 M 2 X F Springfield, MA 95 1916 027-18-9097 December 16. **Director** Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State Director 1 X Yes 2 No Mitchellville Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20721 Funeral 10450 Lottsford Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Black White, etc. Completed by 1 Never Married 2 Married White within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: Maryland 21215-0036 If Yes, Give 3 X Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Education College (1-4 or 5+) 5+ Elementary/Seconday (0-12) High School Teacher 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) h and Mental F Isabel Peck ဂ္ Frank Jackson Clegg and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4615 Amherst Road, College Park, MD 20740 Janet S. Wagner / Daughter Health a other t 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Page 1 of = 5 Alexandria, Virginia 1 Burial 2 X Cremation 3 Removal from State 1/3/2012 Metropolitan Crematory 4 Donation 5 Other (Specify) 4739 Baltimore Avenue 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gasch's Funeral Home, P.A. Hyattsville, MD 20781 once, KAY Royer Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition taclus Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner 700 CC Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Durity or as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death Month Year in the past 12 months?

1 Yes 2 No Pregnant at time of death cate has been signed by the a page 2 should be detached to 9 Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 0 Yes 26. Place of Death (Check only one) 25. Was case referred to medical the funeral director, Be examiner? Other: Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ER/Outpatient 3 DOA 1 Tes 1 Inpatient 2 I မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural 5 Pending 1 Yes 2 No M Investigation Accident 28f. Location (Street and Number or Rural Route Number, Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined City or Town, State) completed filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25 2.

State Registrar - 02 ay

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month Physician/ Joy Dale Sweitzer, Sr. 01 11:10 P M 2012 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett Swanton 597 New Germany Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Davs Hours Min Country 83 **Director** 217-28-0050 1 🛣 M 2 🗆 F Yrs. 1928 MD 10 16 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits death with the Maryland rector 10a. State 10c. City, Town or Location notified at 1 Yes 2 X No MD Garrett Swanton ō 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ms 23a or must be r Funeral 21561 USA 597 New Germany Road "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Hygiene. other than "natura ent, the Medical E Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) county roads mechanic other Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Holma A. Bowser John C. Sweitzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cherry Creek Lane, Oakland, MD 21550 Teresa Feather-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State Pleasant Valley Cem. Oakland, MD 1/10/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home PA Signature of Funeral Service Licenses 2nd St, Oakland, MD 21550 Part 1. Enter the disease, or complications that caused the de .m. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): ear **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No Yes 2 W filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral I To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 3 E 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar North Fourth St, Oakland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

<u>Charles Walch,</u>

JAN-9

M.D.

311

32. Registrar's Signature

Amended it			Please	Type or Pri							-		_	le.	
FH; 01/12/	12	1 _ State		State of M	arylan		oartmei e <i>rtificat</i>			and M	iental Hy				01106
Physici	an/	Registrar 1. Decedent's Name	e (Eirst, Middle, La:	Marie	7	n nd	05	.e or L	,eatr		2. Date of Do	Reg. No eath Da		ar	3. Time of Death 0805 M
Med Exami	ical	4a. Facility Name (if	not institution, give	street and number)		0 16	. 10 '		Location	of Death		40	County of E		0002
Funera		5. Social Security N	152 6. S	ex 7. Age		ast birthday		aklaı er 1 Year Days	nd If Under Hours	24 Hrs.	Garrett 8. Date of Bin /01/15 9. Bir /000/11/15 Co				ce (State or Foreign
Director		Usual Residence of	Decedent		96	Yrs.	<u> </u>	ļ			-08 -1	ナーナン	+5		
aryland a-f sho	Director	10a. State	10b. County			y, Town or l	ocation.							10d	. Inside City Limits 1 Yes 2 □ No
the Ma s or 28 se noti	Dir	MD 10e. Street and Nur	Garrett	-	Uak	land	10f. Zi	p Code	-			10g. Ci	tizen of Wha	t Country	?
th with ms 23.	Funeral	445 Denne	ett Road	12. Was Decedent E		140		550	anania Ori	ining (Con	oifu Voo or No		USA	A	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "Instural", or items 23a or 28a-f show miportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ		Armed Forces? 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.			5.	If Yes, spe				cify Yes or No Rican, etc.)	-	14. Race - American Indian, Black, White, etc. Specify: White		
2 hour	Completed	(Spe	15. Decedent's E	ducation		(Giv	edent's Usu e <i>kind of w</i> o	ork done d	ation <i>luri</i> n <i>g m</i> os	st of worki	ng	16b. k	Kind of Busin	ess Indus	stry
2121 within 7 giene.		Elementary/Sec	onday (0-12)	College (1-4 or 5	5+)	life.	DO NOT us Homen						Own Ho	me	
e filed vertiled of the other event,	To Be	17. Father's Name (e (First, Middle Sturm	, <i>Maide</i> n	Surname)		
aryla nould b nd Mer s mark umatic		Joseph (ype, Print)		19b. Ma	iling Addres	s (Street a			I Route Numb	er, City o	r Town, State	e, Zip Cod	de)
P, Mind 2 sk lealth a lealth a		Phyllis '		ghter		237	Aster	Cir		Terr	a Alta	, WV	26764 ——	·	
mork age 1 a ent of H nt: If ite				Removal from State	C	emetery, cr	oosition (Na ematory or Cemet	other plac	e)		2012	1	.ocation - Cit akland	-	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. "Inturer", o important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam once.		21. Signature of Fu		-			22. Name a	nd Addres		ty Dav		Burd	ock Fu		1 Home PA
		23a. Part 1. Enter t	he disease, or com	plications that caused	the death							-			pproximate
Phyrinian Medica	•	Immediate Cause (disease or condition resulting in death)	Final	ne cause on each line a.		H	ude	V	MI					O d	nterval -, tween
Examine	1			Due to (or as	a consequ	uence of):	+2+	6							14591)
ed sit	Examiner	Se wentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate rlying	Due to (or as	a consequ	uence of):									
e executed ian and urial-transit	1-	that initiated event resulting in death)	S	Due to (or as	a consequ	uence of):									
760 cate be physic s the bu	edica			d										\perp	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 : 1 ☐ Yes 2 & 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	al death 3	☐ Ectopic ☐ Other (s		У				23d. Date o Month		
IS, P.O uires that th signed by Id be deta	<u>a</u>	Part II. Other signif	ficant conditions o	ontributing to death b	ut not res	ulting in the	underlying	cause giv	en in Part	: 1.					cause of death?
Record he law requ te has beer	Completed										per	s an opsy formed?	prio deat	r to comp	y findings available bletion of cause of
tal F cian: T certifica ector, p	Be	25. Was case referre examiner?		Hospital:				26. Pla		ath (Check	only one)	2 2 1		. 100 2	
of Vi g Physi er this o	te: To	1 ☐ Yes 2	h	1 Inpati 28a. Date of inju (Month, Date	ry	ER/Outpat 28b. Time injury		28c. Injury	4 □ N ⁄at	$\overline{}$	me 5 Res 28d. Describe			Specify)	
rision Attendin er death. rector: Aft	Certificate:	Natural Accident	5 Pending Investigatio 6 Could not be determined	n	ıry - At ho	me, farm, s	М		Yes 2		28f. Location City or To			r Rural Ro	oute Number,
Div spital or nours aft neral Dir		29a. Certifier 1	Certifying Phy	sician: To the best of	my knowl	ledge, deat	n occured a	t the time,	, date and	place, an	d due to the d	ause(s) a	nd manner a	s stated.	1
the Horthin 24 https://doi.org/10.1001	Medical	(Check 2 only one) 3	Certifying Nur	iner: On the basis of e se Practioner: To the			e, death occi	urred at the	e time, dat	e and plac	e, and due to t	the cause	(s) and manne	er as state	ed.
o o		29b. Signature and	title of certifier				29	P. License	number 1	133		29a. Da	ate signed (N	12	y, rear)
	7	30. Name and addr Thomas	ess of person who G. Johnso	completed cause of don, M.D.,	eath (Item 311 1	123a) (Type North	Four t	h St	, Su	ite]	II, Oak	land	, MD 2	21550)
Sta Regist	ate rar	31. Date filed (Mont	h, Day, Year) N - 9 201	32. Registra	ar's Signat	ture	M								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ James Edward Scuffins 0033 2012 Medical Jan var 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hagerstown Washington County Meritus Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Mattent/31 1937 214-34-9601 74 Mary Land Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director Hagerstown Maryland Washington County 1 ☐ Yes 2 X No 10f. Zip Code 21742 10e Street and Number 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral 11310 Grouse Lane North 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examiury or other traumatic event the Medical Examiury or other t Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Supply Co. Salesman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Elsie M. Turner Charles Edward Scuffins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 11310 Grouse Lane North Hagerstown, MD 21742 Anna Scuffins-wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Department o Important: If any injury or 1-6-2012 Hagerstown, MD Rose Hill Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart favore. List only one cause on each line. Priset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No cate has been signed by the atte page 2 should be detached for a Month Dav Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONGUNUE HEART PAILURE No 3 Probably 4 Unknown 1 🗌 Yes Certificate: To Be Completed CHRONIE OF TRUCTIVE PULMONORY DISERSE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an SCUPTING death?

1 Yes 2 No RENAL FAILURE ATICIAL FIBRILLATION within 24 hours after death.

To the Funeral Director: After this certificate or Attending Physician: director. Was case referred to medical Hospital: 2 **X**No 1 🗌 Yes 1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) the funeral Manner of Death 28b. Time of 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 🛮 🗻 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) d title of certifie 240622 Name and address of person who completed cause of death (Item 23a) (Type, Print)

XNSST URICANIN MP. 19336 MB7 JW-2+1 MEADOWNIEW DRINGERSSOUN MO 21742 State

DHMH 17 Rev 7/2009

Registrar

James Andrew Simmons

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

J 1						
State	of Marylar	nd / Departme	ent of He	alth and	Mental	Hygien

2	0	1	2	0	-		2	8
- Lon	\sim	- 8	f		- 1	- 1	-	_

		1- For State Registrar	Certificate	of Death		Re		2 0112
Physici ledical Exami		Decedent's Name (First, Middle,Lest)	-			Date of Death Month	Day Year	3. Time of Death 1632 hrs
iedicai Exami	ner	James Andrew Simmons 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loca	etion of Dooth	January 7,	2012 4c. County of Death	
		Harford Memorial Hospital		Bel Air	allorior Dealir		Harford	
Funeral		Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year If	f Under 24Hrs.	8. Date of Birtl		hplace (State or
Director		215-82-0243 13M 2 F	47 ·	Months Days	Hours Min.	6/11/1	Foreign Cou	n untry) MD
		Usual Residence of Decedent				0/11/	1,704	
w any		10a. State 10b. County 10c. (City, Town or Lo	cation				10d. Inside City Limits
faryland 28a-f show	ţo	MD Harford	Bel Air					1 Yes 2 X No
e Mary or 28a	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Coun	try?
with the Maryland ms 23a or 28a-f sho be notified at once		2122 Conowingo Road 11. Marital Status 12. Was Decedent Ever i	niie 113 N	21014 Was Decedent of Hispani	ic Origin2 / Sp	acify Vas or No.	USA 14. Race - Americ	ean Indian Black
item	Funeral	1 Never Married 2 Married Armed Forces?	1	f Yes, specify Cuban, Me			White, etc.	zarrandari, biddi,
ther d	by Fu	3 Widowed 4 Divorced of Yes, Give Year or Dates:	1	Yes 2 X No sp	pecify:		Specify: Wh:	ite
nours .	De De	15. Decedent's Education (Specify only highest grade completed	d) 16a. Deced	lent's Usual Occupation (most of working life, DO			16b. Kind of Business/Ir	ndustry
11215-0036 de filed within 72 hou fental Hygiene. narked other than "nafevent, the Medical Exa	pleted	Elementary/Secondary (0-12) College (1-4 or 5+) 12		v	1101 400 7011		G	
215-0036 be filed within 7 ntal Hygiene. rked other than	Com	17. Father's Name (First, Middle, Last)	поше	Building	Aother's Name	(First Middle M	Constru	uction
2.5 al Hy red of	ВеС	James Andrew Simmons Sr.			Betty :	•	araon camamo,	
212 ould b I Meni	ToE	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ing Address (Street and			per, City or Town, State,	Zip Code)
MD 21 d 2 should Ith and Me n 27 is ma		Lindsey N. Simmons - daughter		Clover Cres		Apt. C		
		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	Ob. Place of Disp crematory or	osition (Name of cemeter other place)		Date 11/2012	20c. Location - City or	Town, State
Page Page ment o			R.T.Foar	d Funeral H			Rising Sun	, MD
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee	22	. Name and Address of F	acility R.	r. Foard	l Funeral H	ome, PA
	_	23a. Part I. Enter the disease, or complications that caused the de		11 S. Queen				21911 Approximate Interval
Physician /Medical	1	failure. List only one cause on each ine.		t the mede of dying, sad	1 40 04 010 01	roopiiatory arro	or, orrear, or recure	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a Heroin Intoxi Due to (or as a consequence)						
		Sequentially list conditions, b.						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	ce of):					
T 15	хап	(Uiscase or injury that initiated events resulting in death) Last Due to (or as a consequence)	ce of):					
'60, rate be executed physician and he burial - transi		d	+ TT 27	,28a-f,per m	me 0923	1-25-1	2 cm	
'60, ate be ex physician he burial	Medical			, 20a 1, per 1	mc,6723	1 25 1		
876 tificat ng ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of p	_	Fetal death 3 E	ctopic pregnar	псу	23d. Date of delivery Month D	ay Year
Box 687 e death certific the attending i ed for use as the	Sicla	4 Pregnant at time o	f death 5	Other (Specify)				
O. By tr the de-	Physiclan/	Part II. Other significant conditions contributing to death but n	ot resulting in th	underlying cause given	in Part I	23e Did tob	pacco use contribute to t	he cause of death?
Vision of Vital Records, P.O. Box 687 or Atteodiog Physician: The law requires that the death certificate death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as the bythe funeral director, page 2 should be detached for use as the funeral director, page 2 should be detached for use as the funeral director.	Ď	Cocaine and Alprazolam Use	or roodking in the	s directlying sause given	inii atti.		2 No 3 Proba	
rds, require been si	Completed					24a. Was a		opsy findings available
cor e law i e has t	Ē					autops	ned? death?	ompletion of cause of
ian: The certificate ector, page		25. Was case referred to medical		26 Place of D	Death (Check o	1 ✓ Yes 2	No 1 Yes	s 2 No
Vital hysician: this certif	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2	ER/Outpatie		er Nursing		Residence 6 Other:	
n of diog Ph.	7: To	27. Manner of Death 28a. Date of Injury	28b. Time o	f Injury 28c. Injury at	Work?	28d. Describe h	ow injury occurred	
ion freedi leath. tor: /	atio	Natural 5 Pending Pending Investigation Fd 1-6-12	fd 19	1 Yes	2 🗶 No	unknow	1	
Division of Vital Records, ral or Atteodiog Physician: The law requires after death. al Director: After this certificate has been sited in by the funeral director; page 2 should t	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - A		reet, factory, office buildii	ng, etc.	28f. Location (Story Town, Story Town, Sto	reet and Number or Rurate) 137 Rigdo	al Route Number, City n Rd.
Divisor Applies or Applies or Applies of App		20a Certifier	Reside			<u>Aberdee</u> i	n,Md.	
Di To the Hospital within 24 hours a To the Fuoeral I completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination						
To wit	Mec	29b. Signature and title of certifier		29c. License nui	mber		29d. Date signed (Mon	th, Day, Year)
4		Carie Husean	againm.	O.C.M.E	i.		January 10, 2012	
()	ŀ	30. Name and address of person who completed cause of death (I	tem 23a)				-	
- 1		Carol Allan, MD Assistant Medical Examiner	900 W. B	altimore Street, Ba	ltimore, MI	21223		
St Regist	ate	31. Date filed (Month, Day Year) 32. Registrar's Sign JAN 19 2012	backet					
DHMH 17 Rev 1/2		OCME		AL				
OCME 2006	-01	OOME	ORIGIN	AL.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death mITh 15 pm Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washing Hageistown cis town ag 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplage (State or Foreign Social Security Number **Funeral** Months Days Hours Min Maryland 215-26-1844 83 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23° ---- any injury or other traumatic event, the Marie and injury or other traumatic event, the Marie and injury or other traumatic event. 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Director Hagerstown Washington 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21742 13840 Marsh Pike Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give 1951 1953 white 1 Yes 2X No Specify. Completed 3 - Widowed 4 - Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) railroad brakeman Be 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) မ Koons Pauline Smith Herman 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13840 Marsh Pike, Hagerstown, Maryland 21742 19a. Informant's Name/Relationship (Type, Print) Mary Crowell Smith - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State January 11.2012 Hagerstown, Maryland Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Minnich Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician/ a disease or condition resulting in death) Medical Due to (or as * onsequence of): **Examiner** Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Examine Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): inding physician i Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse fyes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No ate has been signed by the atte page 2 should be detached for Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at 1 🔀 Natural 5 Pending after death. 1 Yes 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Medical examiner. In the basis of examination around the state of the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010

Registrar

DHMH 17 Rev 7/2009

State

JW-5+

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

omer

CRNP 14014 Marsh Pike

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 22. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 6:20 PM Physician/ January 4 2012 Elizabeth Stewart Medical 4a. Facility Name (if not institution, give street and number)

Laurel Regional Hospi 4b. City, Town, or Location of Death County of Death Examiner Prince George's Hospital Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign Sex . Age (In yrs. last birthday) **Funeral** February 3,1935 Maryland 1 □ M 2 🗓 F Months 76 214-32-9462 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director Maryland Prince George's 1 X Yes 2 No Forest Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20745 USA 58 Talbert Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married by Specify: Black 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry
St. Elizabeth's 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) Hospital Food Service Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed.
Department of Health and Mental Himportant; If item 27 is marked ott any injury or other ferrors. 17. Father's Name (First, Middle, Last) ဂ္ Louise Louis Proctor Martha Smoot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Stewart, Sr - Husband 58 Talbert Dr., Forest Heights, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1XX Burial 2 Cremation 3 Removal from State Resurrection Cemetery 1/10/2012 | Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between On et and Death Immediate Cause (Final Physician erebrovasc disease or condition resulting in death) Medical **Examiner** ldscular Disease ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Mellitus lears burial-transit Cause (Disease or iinjury that initiated events Diabetes Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Parkinsons Disease 24a. Was an autopsy Yes 2 No Sepsis after death.

Director: After this certificate 1 Yes 2 No Hospital or Attending Physician; npleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 🗙 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral E Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year,

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of Seath (Item 23a) (Type, Print)

Thomas H. Burquieres

6

7300

Laurel Regional Hospita

Dusen

Emergency

aurel,

20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Jan. 3 2012 Julia Michie Smith 1:15 P^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12403 Crystal Pond Court Upper Marlboro Prince Georges If Under 1 Year If Under 24 Hrs 8. Date of Birth
(Month, Day, Year,
July 17, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🔀 F Hours Months 229-30-9709 July 1927 Director 84 Virginia Usual Residence of Decedent shov 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director or 28a-f st notified a 1 Yes 2 No Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Page 1 and 2 should be filed within 72 hours after death with the ment of Heaith and Mental Hygiene.

The strength of the street of the strength or items 23a on a strength or or other traumatic event, the Medical Examiner must be.

Uny or other traumatic event, the Medical Examiner must be. Funeral 917 Ray Road 20783 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: USA 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) U. S. Government Specialist Human Resources Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Humphrey Michie ೨ Carrie Welbrock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Talmadge Smith - Son Crystal Pond Ct. , Upper Malboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) George Washington Cem. 1-11-12 Adelphi, MD 22. Name and Address of Facility Signature of Funeral Service License J. K. Johnson Funeral Home P. A. Ave Temple Hills, MD 20748 6503 Old Branch Ave 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ vears Ovarian Cancer Medical Due to (or as a consequence of Examiner Pulmonary Embolism if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 X No Ectopic pregnancy Month Dav Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 2 9 ☐ Unknown After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 🐼 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \times \square$ Other (Specify) Son's home မ 1 Tes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined within 24 hours after

To the Funeral Dire

completed filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 William K. Kelly, M. D. 1400 Forest Glen Rd, Suite 435, Silver Spring, MD 20910

DHMH 17 Rev 7/2009

State

Registrar

pares

32. Registrar's Signature

6 2012

12-00212 Cristian J. Medel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ristian J. Medel	State 1- For State Registrar	of Maryland / Depar Certi	tment of I ificate of L		Mental H		20 leg. No.	2 01132	
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last Cristian		el- Te	norio		2. Date of Dea Month January 7	ath Day Year	3. Time of Death 1626 hrs	
.)	4a. Facility Name (if not institution, give Holy Cross Hospital			. City, Town, or Lo Silver Spring			4c. County of Dea		
Funeral Director		X 7. Age (In yrs. las	t birthday) Yrs.	Months Days 8	If Under 24Hr Hours Mir	,		Birthplace (State or eign Country) MD	
re, MD 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any or traumatic event, the Medical Examinet. must be notified at once. To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State	White, etc. Specify: 16b. Kind of Busines norio Ler mber, City or Town, State Spring, I	erican Indian, Black, White s/Industry ne mus						
Baltimore, MD sed sed sed sed sed sed sed se	4 Donation 5 Other Specify 21. Signify of Furreral Service of ns 23a. Part I. Enter the disease, or complifations. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate (Disease or injury that initiated C	cations that caused the death. D	22 Nar 92 90 not enter the	41 Colu	RTIVALI midia I	DI FUNI Blvd.S:	ERAL SERV ilver Spr		
P.O. Box 68760, that the death certificate be executed by the attending physician and detached for use as the burial - traby Physician/Medical	events resulting in death) Last Due to (or as a consequence of): d. IMAGE UNPENDED AMENDED #1 as noted, 23a, 27, 28a-f, per me, g925 3-15-12 sm IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								
Division of Vital Records Hospital or Attending Physician: The law requesta hours after death. Funcral Director: After this certificate has been tell filled in by the funeral director, page 2 should all Certification: To Be Complete.	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner:	(Month, Day, Year) fd 1-7-12 28e. Place of Injury - At hom (Specify) Car in: To the best of my knowledge, On the basis of examination and	8b. Time of Inju d 4:00 j le, farm, street, retaker 1 , death occurred	DOA Others Ty 28c. Injury a 1 Yes factory, office built S Reside d at the time, date	at Work?	only one) 28d. Describe unknow 28f. Location (or Town, s Silver	prior to death? Residence 6 Oth how injury occurred Street and Number or 6 State) 808 Pat Spring, MD se(s) and manner as st	Yes 2 No No No No Rural Route Number, City Ton Dr. ated.	
2-PEUD	29b. Signature and title of certifier Man Brass 30. Name and address of person who co	and manner stated. A Completed cause of death (Item 23)	3a)	29c. License n O.C.M.	umber E.		29d. Date signed (A January 8, 201	fonth, Day, Year)	
State Registrar	Melissa Brassell, MD As:	sistant Medical Examine 32. Registrar's Signature	See and the second	Baltimore Stre	eet, Baltimo	ore, MD 212	23 		

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ .TANTARY 201^{Year} 13:22 PM DOROTHY K. TAGERT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CECIL UNION HOSPITAL OF CECIL COUNTY ELKTON 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🗓 F Months Hours NOV. I4, 1923 MARYLAND Yrs Director 88 169-20-3924 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ¥ Yes 2 □ No ELKTON MARYLAND CECIL 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? with 1 23a Funeral UNITED STATES 269 MACKALL STREET 21921 items? hours after death 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11 Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3√ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry pernit. Page 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any Injury or other traumatic event, the Medi (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) RETAIL CLOTHING SALESPERSON Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ EMILY B. KEITHLEY UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 92 HOBART DRIVE, APT. B4, NEWARK, DELAWARE 19713 EMILY FORD / NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State JANUARY 5. cemetery, crematory or other place) 2012 NORTH EAST, MARYLAND HARTS CEMETERY 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 21. Signa re 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Prysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying as a consequence of Cause (Disease or iiniury use as the burial-tran that initiated events Due to (or a resulting in death) Last consequence of: physician Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day 5 Other (specify) Pregnant at time of death the detached g 🗌 Unknown 9 Unknown à contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Onknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending injury 1 \(\text{Yes} 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific

Registrar

DHMH 17 Rev 7/2009

State

ark

32. Registrar's Signature

KIEW

and address of person who completed cause of death ()

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ рМ January 5:15 Harriet Virginia Tarr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Ellicott City Heartlands If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Months Hours Min. 1 M 2 SE 0270371927 84 Director 180-22-0817 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10c. City, Town or Location 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director "natural", or items 23a or 28a-f s edical Examiner must be notified Ellicott City 1 Yes 2X No MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21043 3004 North Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status à 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Government Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Harriet M. Botzer Morgan Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4219 College Avenue Ellicott City, MD 21043 Roger Tarr - Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Date permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place, ☐ Burial 2 X Cremation 3 ☐ Removal from State 01/04/2012 Hanover, MD Ardent Crematory 4 Donation 5 Other (Specify) 21. Sign rure of Funera Service ice see 22, Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 🗌 Yes 2 🗌 No this certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Assisted Hospital Other: 2 **X**No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ျ 4 Nursing Home 5 Residence 6 Nother (Specify Living 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Funeral Director: After completed filled in by the funer work?
1 Yes 2 No injury 1 XNatural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) 24 hours a Hospital Medical 1 🗶 Certifying Physician: To the best Jurry knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29c. License number January 4, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Columbia, MD 21044 Andrew Lazris, MD 6334 Cedar Lane 31. Date filed (Month, Day, 32. Registrar's Signature State RELAND Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2012 1:30PM M JAN. UNCIANO FELIPA L. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S FT. WASHINGTON FT. WASHINGTON REHABILITATION If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 □ M 2 🔀 F 1919 PHILIPPINES 6, AUG. 553-50-9121 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. and: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 🔀 No ALEXANDRIA VIRGINIA FAIRFAX Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 22306 3005 FRANKLIN STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 21215-0036 þ ASIAN 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) rthan the M College (1-4or 5+) Elementary/Secondary (0-12) BEAUTY SHOP SELF EMPLOYED 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be BASILIA GARCES JOSE LEON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 FRANKLIN STREET ALEXANDRIA, VA 22306 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health at Important: If item 27 is any injury or other trauonce. ISAAC UNCIANO/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON, VA ARLINGTON NATIONAL 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility DEMAINE FUNERAL HOME 21. Signature of Funeral Service Licensee 520 S. WASHINGTON STREET Iana ALEXANDRIA, VIRGINIA 22314 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. such as cardiac or respiratory prest, Do not enter the mode of dying, Lever Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached to 9 I Inknown 9 Unknown 23e. Did tobacco use coptribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☐Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes / 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Man r of Death 1 atural 28a. Date of Injury 28b. Time of (Month, Day Year) Injury 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined filled in by 4 Homicide 24 hours a Hospital 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2-To the F 29d. Date signed (Month, Day, Year) 29c. Nicense number 29b. Signatur and title of certifier

CR 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAXMI BERWA 7700 OLD BRANCH RD. SUITE C #101 CLINTON, MD 20735

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ PM Dorothy Marie Wolfensberger 5:42 January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hagerstown Washington Meritus Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, une 17 Hours Min. 214-28-0450 81 Director Maryland <u>June</u> Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Washington Hagerstown 10e Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or Funeral 72 hours after death with 16733 National Pike 21740 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, an "natural", or ite Medical Examiner Black, White, etc. 1 Never Married 2 Married þ Yes 2 Mo Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: white Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) the retail store cook Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Laura Bell Decker William Ernest Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Berry - nephew 152 Tiara Ct., Falling Waters, WV 25419 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 1/7/12 Hagerstown, Md. 21740 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Neumon Physician disease or condition) Medical resulting in death) Due to (or as a conse Examiner Res Sequentially list conditions, if a y, leading to in reclars cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death ped the P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. 1 Yes 2 No 3 Probably 4 Tonknown Completed plnods peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? this certificate has page 2 1 Yes 2 No 2 1 Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After leted filled in by the funer. 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined completed filled in Medical 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 00062006 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

TW-10

10)

2012

31. Date filed (Month, Day, Year)

MAL

MYAKO

eistrar's Signature

32.

ULILLE MÓDICAL

Hagerstown, 40

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 4, 2012 6:40 P Wilburn Robert Carl Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death WMHS-Frostburg Nursing & Rehab Center Frostburg Allegany 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🖳 M 2 🗆 Country)MD Dec 3.1. ^{(ear}1932 **Director** <u>218-30-</u>0717 79 Usual Residence of Decedent or 28a-f show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Mount Savage MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21545 P.O. Box 562 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian ò 1 Never Married 2 X Married Black, White, etc. Yes Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Divorced Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 Ind Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Carpentry carpenter uth and Mental H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hazel Custer Norman Wilburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 562 Mount Savage MD 21545 Mary Wilburn 1 and 2 s of Health a item 27 i wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō Important: If in any injury or o Page 1 1 X Burial 2 Cremation 3 Removal from State Mount Tabor Cemetery 1/9/2012 MD Spring Gap Donation 5 Other (Specify) ignatur of Funeral Service 22. Name and Address In Furtheral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Deatl Phynician Cancer months Medical resulting in death) Due to (or as a onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burialending physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? ò Month Day Year Pregnant at time of death signed by the at d be detached for Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>8</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No after death.

Director: After this certificate 1 ☐ Yes 2 No 25. Was case referred to medical completed filled in by the funeral director Certificate: To Be 26. Place of Death (Check only one) 2 X No Hospital Other: 1 A Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? Accident Investigation 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I worksh 00055325 Jan 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) walsh Rd Cumberland MD 21502 Bishop SHIN Mn 925 WONSOCK Day, Year, 32. Registrar's Signature State 9 2012 JANO Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 4, 2012 Physician/ Edwin E. Yoder 2:40 P. M Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Garrett Goodwill Mennonite Home Grantsville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth Funeral 7. Age (In vrs. last birthday Days Apr 4, Day 1921 1 🕱 M 2 🗆 F Maryland Director 90 220-16-6909 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Director 1 ☐ Yes 2X No Somerset Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15562 USA 1908 Springs Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 **K** No white Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farming 7 th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Anna Beachy Edward M. Yoder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Livingston/Stepson & PR 11261 Clarence Center Rd., Akron, NY 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Springs Cemetery Jan 7, 2012 Springs, PA Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. Box 275, Grantsville, MD 21536 ol 179 Miller St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the I as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant for in the past 12 months? Year Month Day Pregnant at time of death 2 No the be detached g Unknown signed by Part II. **Other significant conditions** contributing to death but not res<u>ult**in**g</u> in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No After this certificate ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 X No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 24 hours after death. Funeral Director; A 2 No Investigation Accident the. 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Muhammad

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 5, 2012 11:00 AM Beverly Gleen Young Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Emeritus Senior Living Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth . Age (In yrs. last birthday) **Funeral** Sep. 14, 1921 1 🛛 M 2 🗆 F Mary Land 183-14-8633 **Director** 90 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
I tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Maryland Washington County 1 Yes 2 No Hagerstown 10f. Zip Code 10g. Citizen of What Country? Funeral 20009 Rose Bank Way 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S Types 2 1943-Yes, Give 1946 Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 🂢 No White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Herman D. Young Rachel Shaul permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Kelley-daughter 10827 Rosewood Dr. Hagerstown, MD 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 1-6-2012 4 Donation 5 Other (Specify) |Smithsburg, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 attun 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ WYONG disease or condition Medical resulting in death) Due to (or as a consequence of Examiner E squentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) he law requires that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 5 1 L Yes 2 L 9 D Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy funeral director, page 2 certificate To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛱 No nours after death. neral Director: After this or I filled in by the funeral dire 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 9 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injurv work? 1 Matural 5 Pending 2 🗆 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) address of person who completed cause of death (Item 23a) (Type, Print) 21742 Scim egistrar's Signatu 31. Date filed (Month, State 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gertrude Louise Aversa Medical 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number, County of Death **Examiner** timo ranklinsquare ose HOSP, ta da 8. Date of Birth . Birthplace (State or Foreign **Funeral** July 10, 215-28-7440 Director 1 🗆 M 2 🛛 F 80 Yrs. Balt., Maryland 1931 Usual Residence of Deced 28a-f shov 10d, Inside City Limits 10b. County aţ 10a. State 10c. City. Town or Location Director notified 1 Yes 2 No Maryland Baltimore Perry Hall 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America ō Examiner must be Aversa, Gertrud 23a 21128 9506 Amberleigh Lane Unit N items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2XXNo Black, White, etc. an "natural", or i Medical Examin þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 Yes 2XXNo Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accounting Firm or other traumatic event, the 12 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Childs Chauncey Goodman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21128 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important. If item 27 is any injury or other trauonce. 9506 Amberleigh Lane Unit N Perry Hall, MAryland Mr. Anthony Aversa/ husband 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel – Bel Air January 16, 1 Burial 2XXCremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Fundal Service Licensee Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Approximate Interval Between se on each lil Onset and Death Immediate Cause (Final Physician/ monal disease or condition resulting in death) Medical Examiner ive Pulmonary Disease Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of) physician ar Physician/Medical requires that the death certificate be Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Pregnant at time of death Month Day Year 1 ☐ Yes 2 ₺ 9 ☐ Unknown the a Unknown P.O. signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate has perform 1 Yes 2 No Yes Division of Vital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 TNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death. To the Funeral Director, After this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) iniury 1 Natural 5 Pending 1 Yes 2 No Investigation the Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FranklinSquare 9000 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death leison Month Physician/ ATION Januar Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** E. Belvedere Ave. Baltimore Apt. 101 N/a 5 Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Day Year) Hours 217-24-1762 Director 1 □ M 2 🗶 F 80 4/8/1931 MD Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a, State 10c. City. Town or Location must be notified at Director MD N/A Baltimore 1 Yes 2 INo 10e Street and Number 10f Zip Code 10g. Citizen of What Country? o Items 23a Funeral 1651 E. Belvedere Ave. Apt.101 21239 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 11. Marital Status Examiner es, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc or þ 1 Never Married 2 Married ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black "natural". 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life, DO NOT use retired United States Elementary/Secondary (0-12) College (1-4 or 5+) Mail Clerk Postal Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Smith Blanche Smith 19a. Informant's Name/Relationship (Type, Print)
Calvin Anderson-Son Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 4002 Pinkney Rd. Baltimore, MD 21215 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 1/19/2012 Randallstown, MD King Memorial Pk. 22. Name and Address of Facility March F/H East 1101 E. North Ave. Baltimore, MD 21202 Signature of Funeral Service Licenses Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ 00 disease or condition Medical resulting in death) Dug to **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Mole Examine Cause (Disease or injury that initiated events trar resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death the g Unknown P.O. | signed by the detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed peen Were autopsy findings available 24a. Was an autopsy performed? Yes 2 2 No prior to completion of cause of death? has page 2 1 ☐ Yes 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer Matural 5 Pending Accident
Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29d, Date signed (Month, Day, Year) 29b. Signature and title of of death (Item/23a) (Type, Print 30. Name and address of person who completed caus

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day

Kaver

2

80

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2 Date of Death Physician/ Infudici 16 20 Medical or Location of Death 4c. County of Death Eacility Name (if not institution, give street and number Examiner Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 62 Director 1 X M 2 □ F 3/20/1949 MD Show 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland at Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No altimore 10g. Citizen of What Country? Funeral 21206 USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates er than "natur , the Medical I 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Self Employed 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Employed 14 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ and 2 should be the Health and Ments Allen traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. <u>5</u>8 28 HTMORE, MD 21206 10n Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other p Halethorpe, MM 124/2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fun ral Service Licensee 22. Name and Address of Facility March PlH East 1101E. North Are 21202 MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1515 disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be exe Physician/Medical P.O. Box 68760 the as IF FEMALE: signed by the attending d be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes 2 X No page 2 🗌 No 1 🗌 Yes this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita 2 No ြု 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Deat 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. I Director; After t Certificate: work?
1 Yes 2 No injury Natural 5 Pending 1 Accident Investigation the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined within 24 hours af

To the Funeral D

completely filled i Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Marke Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number person who completed cause of death (Item 23a) (Type, Print) 30. Name and 600 North Wolfe Street State Registrar

2-00407 licolette Alexan	dria		e or Print II ate of Maryla						2 N	12 0114
		- For State Registrar			rtificate o				eg. No.	12 0111
Physicia	ın/	Decedent's Name (First, Middle)	e,Last)					2. Date of Deat Month January 14		3. Time of Death 0844 hrs
Medical Exami		Nicolette Ale 4a. Facility Name (if not institution	xandra Al	t Imber)		4b. City, Town, o	r Location of D		4, 2012 4c. County of E	
		Franklin Square Hosp			1	Rosedale			Baltimore	•
Funeral	П	5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Yes		Min	F	9. Birthplace (State or oreign
Director	L	214-33-8893	1 M 2 X F	2	O Yrs		ys riodis	July 3	,1991	Country) Maryland
any	- 1	Usual Residence of Decedent 10a. State 10b. County	-	10c. City,	Town or Local	ion				10d. Inside City Limits
k	_	Md.	Balto.		N	ottingha	am			1 Yes 2 XNo
Maryland 28a-f show	Director	10e. Street and Number				10f. Zip Code		10	og. Citizen of What	Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		8 Delgreen Co				2123			USA	No.
ath wit	Funeral	11. Marital Status 1 X Never Married 2 M	arried Armed F					? (Specify Yes or No- uerto Rican, etc.)	- 14. Race - A White, e	American Indian, Black, etc.
fter de			orced If Yes, Give Yes	2 X No	1	Yes 2 No	o specify:		Specify:	White
ours a	å þ	15. Decedent's Education (Spe				nt's Usual Occupa			16b. Kind of Busin	ness/Industry
36 in 72 h	Completed by	Elementary/Secondary (0-12)	College (1	I-4 or 5+)		Student		- /	Colle	ege
d with ygiene ther there	ĕ	17. Father's Name (First, Middle,	Last)				18.Mother's N	Name (First, Middle, M	Maiden Surname)	
215 be file ntal H	B	Steven D. Alt			131.000			chele A. D		
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than numatic event, the Medica	٤	19a. Informant's Name/Relations			19b. Mailin			er or Rural Route Num		
and 2 sealth stem 27	ŀ	Michele A. Dr 20a. Method of Disposition	cost			sition (Name of ce		Durt Nott	20c. Location - C	
Baltimore, permit. Pages I ar Department of Hee important: If ite		1 X Burial 2 Cremation		om State Du	crematory or ot laney \	her place) 7alley	1-	-19-2012	Timonium	n, Md.
ultin nit. Pa artmer sortan iry or	ł	4 Donation 5 Other Si 21. Signatuje of Funeral Service			22.1	Name and Addres	ss of Facility	Schimunek	I FuneralHo	ome, Inc.
E Per Det		Manuel ll	14/					ad Nottin		
Physician Wedical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.						est, shock, or heart	Approximate Interval Between Onset and Death
xaminer	ĺ	Immediate Cause (Final disease or condition resulting in death)		1am and	Fentan	yl Intox	<u>xicatio</u>	n		Deatil
S.		Sequentially list conditions,	b							
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence o	of):					
E 0 18	хап	(Disease or injury that initiated events resulting in death) Last		consequence o	rf):					
i, P.O. Box 68760, ires that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	ical Examiner	UNPENDED	dAMENDED							
60, ate be ohysicia	Med	IF FEMALE:	23c. If yes,	outcome of preg	nancy				23d. Date of de	elivery
687 certific nding p	jan/	23b. Was decedent pregnant in the past 12 months?	I I CIVE I	oirth nant at time of de	oth -	etal death 3	Ectopic p	regnancy	Month	Day Year
Box death he atter	Physician/Med	1 Yes 2 No 9 V Uni			2 □ 0	ther (Specify)				
hat the detache	by P	Part II. Other significant condit	ions contributing to	o death but not r	esulting in the	underlying cause	given in Part I	I. 23e. Did to		re to the cause of death? Probably 4 V Unknown
duires ten sign	ted									ere autopsy findings available
cords, law requir has been s	Completed								rmed? dea	or to completion of cause of ath?
Vital Reco	Š	25. Was case referred to medica				26.Plac	e of Death (Cl	1 Yes	2 No 1	Yes 2 No
Vita ysicial this cer direct	To Be	examiner? 1 Yes 2 No		Inpatient 2	ER/Outpatien	B 3 DOA	Other ₄ N	Nursing Home 5	Residence 6	Other:
ing Ph		27. Manner of Death		of Injury , Day,Year)	28b. Time of		ury at Work?		how injury occurred	
SiOr Attend death ector: by the	catic	2 Accident Inve	stigation	-14-12	fd 080	et, factory, office	Yes 2X N		Street and Number	or Rural Route Number, City
DIVI	Certification:		d not be rmined (Specify)			ot, ractory, office	Daniania, oto.	or Town, S	state) 317 Cap	itol Ct.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying P		st of my knowled	lge, death occu			e, and due to the caus	se(s) and manner a	
To the within To the comple	Medical		and manner s		and/or investiga		on, death occur	rred at the time, date		o to the cause(s)
	2	29b. Signature and title of certific	NEADO	c/ 1 .			.M.E.		January 15,	
4	ŀ	30. Name and address of person	who completed cau	se of death (Iten	n 23a)					
Y			sistant Medical			timore Stree	t, Baltimore	e, MD 21223		
Si Regis	ate	31. Date filed (Month, Day, Year)	32. R	egistrar's Signat	ake					
L/cals	المتعد	THE THE THE	- Marine		Mary Comment					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Thomas Barnes <u>17,2012</u> 12:30 P.M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cockeysville Baltimore County Broadmead Retirement Community 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 6. Sex Age (In yrs. last birthday) 1 X M 2 □ F 722-12-3543 May 13, 1926 Baltimore, MD. Yrs. Director 85 Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Cockeysville 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 United States 13801 York Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1

Yes 2 No Navy

If Yes, Give N T T Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 27 is marked other than "natural", traumatic event, the Medical Exar Specify. 3 XWidowed 4 Divorced Completed Year or Dates. W.W.II 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) rould be filed within 72 nd Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Johns Hopkins Hospital Chief Financial Officer 04 Be 18. Mother's Name (First, Middle, Maiden Surname)

Madeline Caroline Gray 17. Father's Name (First, Middle, Last) ပ္ John Irwin Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 stranger to the perturn of Health at Important: If item 27 is any injury or other trau Lutherville, Maryland 21093 1201 Purdy Court Mr. John I.Barnes, II (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Harford County) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Evans Funeral Chapel and Wednesday Borns 4 ☐ Donation 5 ☐ Other (Specify) Jan. 18, 2012 Forest Hill, Maryland Cremation Services, Inc. Percent Alternatives Funeral and Cremation Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 🗌 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the detached 9 Unknown P.O. þ ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 12 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed certificate 2 🗆 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA Sursing Home 5 Residence 6 Other (Specify) this eral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 201 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 150 0 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Tate House Hospice of the Chesapeake Linthicum Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Months 220-20-2043 85 Director 1 M 2 W MD 08/25/1926 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland Examiner must be notified at Director MD Baltimore Baltimore 1 Yes 2XXNo 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2905 Georgia Ave. 21227 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 72 hours after Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify. Specify: If Yes, Give "natural" 3 X Widowed 4 □ Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Self-employed Homemaker 12 and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary E. Ford permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or or or. Ivan J. Soderstrom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3704 Century Ave., Baltimore, MD 21227 Carole Bush-Binaut / Daughter Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)

Cedar Hill Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 101/23/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 , ai M01452 - Ker Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ACCIDENT ASCHUR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the as attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown the 9 Unknown Records, P.O. n signed by tall Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been significate has been significated and alternation and a should the same of the sam 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) TATE မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of HOUSE 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer injury 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number Z 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registra

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 11:58 AM 18, January Medical Fay Morton Butler 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death

Baltimore Timonium Stella Maris Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 11/27/1934 214-34-1497 77 Maryland Director 1 **X** M 2 □ F Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Middle River Baltimore 1 Yes 2 X No Maryland 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Funeral U.S.A. 21220 19 Compression Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 🔀 Yes 2 🗆 No If Yes, Give Black White etc 1956by 1 Never Married 2X Married 21215-0036 1 Yes 2X No Specify. 1962 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore County Parks and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor & Recreation Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Remina Durst Department of Health and Meni Important: If item 27 is marke any injury or other traumatic Melvin Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Step-Randy Austin Williams Left Wing Drive, Baltimore, Maryland 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard 01/21/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenset 22. Name and Address of Fasility inski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shack, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month 5 Other (specify) Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records. 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e 2 autopsy performed? Yes 2 X N 1 Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 X No မ 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hin 24 hours a the Funeral D npletely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I only one 29b. Signature and (itle of cer License number 29d. Date signed (Month, Day, Year) 18/ 12

State

E

d

11:58

2012

18,

JANUARY

BUTLER

MORTON

FAY

Registrar

DHMH 17 Rev 06-2011

parke

2300 DULANEY VALLEY RD.

32. Registrar's Signature

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD, MD

31. Date filed (Month, Day, Year)

JAN 2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene.

IIIIaiii Diiii		- For State Climaryland / Department of Health and Menta - For State Certificate of Death - tegistrar		Reg. No.	
Physiciar ledical Examin	1/	1. Decedent's Name (First, Middle,Last) William Brill	2. Date of Dea Month January	ath	3. Time of Death 1128 hrs
med .	ı	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of I 2321 Maytime Drive Gambrills		4c. County of Death Anne Arundel	1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1	24Hrs. 8. Date of B	irth (MM/DD/YYYY) 9. Bir	
Director	L	99-22-1753 _{1XM 2-F} 57 _{Yrs.} Months Days Hours	Min. 10/1	5/1954 Foreig	untry) NJ
/any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Aaryland 28a-f show 1 at once.		MD Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	2	10e. Street and Number 2321 Maytime Drive 21054		USA	iu y r
r death wi	by Funeral	11. Marital Status 1 XNever Married 2 Married 1 Yes, Give Year 1 Divorced or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Specify Cuban, Mexican, P 1 Yes, Specify: 1 Yes, Give Year 1 Yes Specify: 1 Yes Specify:		o- 14. Race - Ameri White, etc. Whi Specify:	ican Indian, Black, te
hours a		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kinduring most of working life. DO NOT us		16b. Kind of Business/	Industry
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene. 7 is marked other than "natural", antic event, the Medical Examiner.	Comple	0 Disabled		Disable	ed
21215-0036 uld be filed within 7 Mental Hygiene. Marked other than e event, the Medica	200		Name (First, Middle, sie Levi	•	
the MD 2121 and 2 should be file and 2 should be file and 2 should be file and 1 should be file and 1 should be file and 2 should be f	9	19a. Informant's Name/Relationship (Type, Print) Deborah Suarez Cousin 19b. Mailing Address (Street and Number 19b) 2321 Maytime Dr		-	
e, MD 1 and 2 sho Health and item 27 is	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date Date	20c. Location - City or	
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traus		4 Donation 5 Other Specify: Atlantic Crem	1/17/12	Glen Bu	
Balt permit. Depart Import injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Allen PA			
Physician	7	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carrifailure. List only one cause on each line.			Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a Acute Pneumonia Due to (or as a consequence of):			Death
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examine	cause. Enter Underlying Cause (Clistose or in jury that initiated			
ecuted and transit		d d	22 12		
60, ate be exe hysician a		IF FEMALE: 23a, pt. 11, 2/, per me, g924 2-2	ZZ-1Z SIII	23d. Date of deliver	<u></u>
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		2h Mas decedent program in the	pregnancy		, Day Year
P.O. B. ss that the de gned by the e detached f	<u> </u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		tobacco use contribute to	
ds, P.C.		Hypertensive Cardiovascular Disease	24a. Was	an 24b. Were au	topsy findings available
of Vital Records, ig Physician: The law require then this certificate has been si meral director, page 2 should b	Completed		auto perf 1 ✓ Yes	propried propried death? 2 No 1 ✓ Ye	completion of cause of es 2 No
ital Relician: The scertificate rector, page	P P	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Inpatient 2 Inpatient 3 DOA Other 4 Inpatient 2 Inpatient 3 Inpatient		Residence 6 🗸 Othe	r: Scana
ling Phys	의	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurred	
Division tall or Attendil rs after death.	Certification	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory office building, etc.		(Street and Number or Ru	ural Route Number, City
Div spital on nours aft		4 Homicide determined (Specify)	or Town,		
To the Hospital Within 24 hours To the Funceal completely fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the cau urred at the time, date	use(s) and manner as state and place, and due to the	ed. ne cause(s)
7.84.8	Me	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo	
Je nil	-	30. Name and address of person who completed cause of death (Item 23a)		January 8, 2012	
2 Paris		Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, M	D 21223		
Sta Registr	te ar	31. Date filed (Month, Day, Year) JAN 2 0 2012 Separa S. Sank			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State	of Mary		artment of I rtificate of L			'7	012	01149	
		Registrar 1. Decedent's Name (First, Middle	, Last)		Ce	runcate or t	Jean	2. Date of Dea	Reg. No. 5	0	3. Time of Death	
Physicia		Togoph Charles Parrance Month								Day Year		
Medic Examin		4a. Facility Name (if not institution			4b. City, Town, o	r Location of Deat		_	inty of Death			
		Genesis Healt				Easto				Talbo		
Funeral Director		5. Social Security Number 216–05–0665	6. Sex 1 XM 2 □ F		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day Aug 30,	1913	9. Birthp Count Maryl	lace (State or Foreign ry) and	
T OM		Usual Residence of Decedent										
uryland a-f she iled at	ctor	10a. State 10b. County	7		c. City, Town or Lo					1"	0d. Inside City Limits 1 ☐ Yes 2 🔀 No	
he Ma or 28a o notif	Dire	MD Howard 10e. Street and Number	a	_ W	oodstock	10f. Zip Code			10g. Citizen	of What Coun		
s 23a ust b	Funeral Director	1876 Woodstock Road 21163							USA			
death r item iner m		11. Marital Status	12. Was Dece Armed Fo	rces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)		14. Race - American Indian, Black, White, etc.		
s after al", o	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If You Giv	2 X No /e ates.		1 ☐ Yes 2 🛛 No	Specify:		Spe	Specify: White		
2 hour	plete		nt's Education est grade completed			dent's Usual Occup		rkina	16b. Kind o	Kind of Business Industry		
thin 73	Completed	Elementary/Seconday (0-12)	College (1		life, L	OO NOT use retired) Driver			Tranci	∞rtati	on	
iled w I Hygi other vent, t	Be	17. Father's Name (First, Middle, L	ast)		Truch	DIIVCI	18. Mother's Na	me (First, Middle,			011	
yld be fill be family Menta arked arked artic er	욘	Charles Freder	ick Barra	nco			Fannie V	an Fosse	n			
perfullingtey, Mary yialing Z.I.Z.13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Saa or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsi Charles F. Bar:				ng Address <i>(Street</i> Rivervie w						
of Head		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	· · · · · · · · · · · · · · · · · · ·		20b. Place of Disp	osition (Name of matory or other place	ce)	Date	20c. Locati	on - City or To	wn, State	
mit. Page 1 partment of portant: If it y injury or o		4 Donation 5 Other (S	(pecify)	r State F	inal Jou	rney Crem	natory 01	-		ine, MC		
permit Depart Impor any in		21. Signature of Funeral Service L	iponsot Heild	le mo	1251 B	oing Home everly L.	e Cremati Heckrot	on Servi	ce P. Clari	.O. Box	784 , MD 21029	
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that	caused ach lin	death. Do not en	er the mode of dyir	ng, such as cardia	or respiratory arr	est,		Approximate Interval Between	
Ph_sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	1901	all for	elure 1	THY	ive			Onset and Death	
Examiner		Toolaning in adding	Due to	(or as a co	nsequence (1):	Lunei	tio				wers	
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to	(or as a co	nsequence of):	, -, -, -						
ecuted and transi	xam	Cause (Disease or iinjury that initiated events resulting in death) Last	c. — Due to	(or as a co	nsequence of):					-		
rate be executed physician and the burial-transit	dical Examiner	resulting in death) Last	L	(0, 00 0 0								
ificate ig phy as the	Medi	JF FEMALE:	u									
th certifications as as as	ian/I	23b. Was decedent pregnant in the past 12 months?		Birth 2	Fetal death 3	Ectopic pregnan	су		23d	. Date of delive	ery Day Year	
requires that the death certificate been signed by the attending p should be detached for use as t	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Preg 9 ☐ Unk	nant at tim nown	ne of death 5 l	Other (specify)				Worter	Day (Cal	
that the ned by a detact	y Pt	Part II. Other significant condition	_		ot resulting in the	underlying cause gi	ven in Part I.	23e. Did to	bacco use o	ontribute to th	e cause of death?	
quires quires en sig	ted t	Pinhetes)	isim					1 🗆 '	Yes 2□N	lo 3 🗆 Prok	pably 4 hknown	
law requires has been sig	Completed by	Denactes /	nodifus					24a. Was autop	sy	prior to co	osy findings available mpletion of cause of	
The icate I		OC Was and referred to reading!						1 🗆 Yes	rmed? 2 No	death? 1 🗌 Yes	2 □ No	
siciar sicertificato	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Innationt	2 ER/Outpatie	Oth	lace of Death (Che	ноте 5 🗆 Resid	ionoo 6 🗆	Other (Specific	1	
og Phy ter this neral c		27. Manner of Death Natural 5 ☐ Pendir	28a. Date		28b. Time o		y at	28d. Describe h				
or Attendir frer death. irector: Af n by the fu	Certificate:	2 Accident Investig	gation			M 1 🗆	Yes 2 No					
al or Al s after (4 Homicide determ		e of Injury - ing, etc. (S)		reet, factory, office		28f. Location (S City or Tow		imber or Hurai	Route Number,	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical E		sis of exam	ination and/or inve	stigation, in my opini	on, death occurred	at the time, date a	nd place, and	d due to the car	use(s) and manner stated.	
To the within To the comple	Σ	only one) 3 L. Certifying 29b. Signature and title of certifie	Nurse Practioner:	10 the best	or my knowledge,	29c. Licens				gned (Month, I		
)	MULBY	4,1	110	1	72593	3		18.2	2012	
21			OWLKY M	0	610 D	Print) VICHMAN	's LANG	- FAST	on, 1	an a	1601	
Sta Registra		31. Date filed (Month, Day, Year) JAN 2	0 2012 32. [gistar's S	Signature 4	harles						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2012 8:53 PM SUSAN BAXTER BELL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Hours Director 1 M 2 X F 137-40-5078 July 26, 1946 New Jersey 65 Usual Residence of Dece or 28a-f show 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. Count 10d. Inside City Limits Director 1 Yes 2X No MD Frederick Woodsboro 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9609 Gravel Hill Road 21798 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married <u></u> Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 4 Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Joseph Douglas Bell Jean S. Baxter and 2 should be Health and Merem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Douglas Bell/brother 1785 Hillmeade Square Frederick, MD 21702 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State Final Journey Crematory 01/20/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signaturs of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 L Felar Co.
Pregnant at time of death in the past 12 months? Day Month Year 1 Yes 2 Unknown the g 🔲 Unknown Division of Vital Records, P.O. à Part JI. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hospital or Attending Physician; The law requires 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perforn After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 within To the the 29d. Date signed (Month, Day, Year) 29b. Signa re and title of certifier 2012 Name and address of person who completed cause of death (Item 23a) (Type, FREDBULK MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 21. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Benfer Grace 0120 2012 January 18, Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Columbia Gilchrist Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept 5, 1905 106 577-22-5884 1 □ M 2 🗶 F Director Washington, D.C. Usual Residence of Deceden or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1X Yes 2 No Hyattsville MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 0 10e. Street and Numbe ms 23a or must be Funeral 20783 USA 7210 23rd Avenue within 72 hours after death with 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten important: If item 27 is marked other than "natural", and injury or other traumatic event, the Medical Examiner and any injury or other traumatic event, the Medical Examiner. Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lelia O'Neill (unk) Kestler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7210 23rd Ave. Hyattsville, MD 20783 James Benfer/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Hospital 01/19/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ PNEUMONIA DAUS disease or condition resulting in death) Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 1 Yes 2 9 Unknown n signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has death?
1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA မ eral Director: After this of filled in by the funeral dii 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 64395 JANUARY 18, 2012

Registrar

DHMH 17 Rev 06-2011

State

6336 CEDAR LANE COLUMBIA, MS 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE -31. Date filed (Month, Day, Year)

DOBERMAN, MD

Registrar DHMH 17 Rev 06-2011

State

29b. Signature

Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

29c. License number

12-00224 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Branch Brown 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Day January 8, 2012 Branch Brown 1050 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 1401 Lakewood Ave Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Foreign Director 11/1936 Country) VA -32-9855 1 M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Baltimore Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatte event, the Medical Examiner must be notified at once. Director 10g, Citizen of What Country? USA akewood Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 8lack, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Armed Forces? 1 Yes 1 Yes 2 No specify: Specify: Black 3 Widowed 4 Divorced If Yes, Give Year Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) City of Baltimore Elementary/Secondary (0-12) College (1-4 or 5+) ath Driver 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Redo -lorence Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brown Wyanoak Ave, Baltimore, MO 20b Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c, Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2012 4 Donation 5 Other Specify. Signature of Funeral Service Licensee March F/H East 1101 E. North MO 21202 Approximate Interval 23 Tart I. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last **Bospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. ned by the attending physician and detached for use as the burial - transi Physician/Medical x AMENDED #9, per fh, g924 2-9-12 sm UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No After this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification To the Bosp...
within 24 hours after u.e..
To the Funeral Director; A

Gilled in by the f 1 V Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 9, 2012 O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. 31. Date filed (Month, Day, Year) egistrar's Signatu State Registrar

30. Name and address of person who completed cause of death (Item 23a)

OCME

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1-19-2012 Physician/ Mary G. Blimline 9:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Future Care North Point Dundalk If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 1 □ M 2 🖼 F Min. Months Days Hours 7-21-1916 95 Mass. 033-07-4282 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No Baltimore Dundalk MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 206 South Woodwell Road 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 ☐Xio Black, White, etc þ 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Ownhome Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frank Kimble Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Hoffman <u>Fr</u>iend 206 South Woodwell Road Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-21-2012 Rosedale, Maryland Garden of Faith Cem 21. Signature of Funer Servi License Connelly Funeral Home of Dundalk, PA M01176 7110 Sollers Point Road Dundalk, MD 23a. Part 1 Enter the disease, or complications that causes shock, or heart failure. List only one cause on each line enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shook, or heart failu Interval Between Onset and Death tollrane Ph_sician/ eman disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Securettally list our differs Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ed by 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been signe completed filled in by the funeral director, page 2 should be or 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 \ No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

State Registrar

M.D

31. Date filed (Month, Day, JAN 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PASEEM

709

-19-2012

				Plea	se Type o AMEN State	r Pri	nt in E	Black Ir	delible l	k ₃ En	sure 4	VI Copie	s Ar	e Leg	ible.		
			For State Registrar			O1 1VI	ai yiai k		tificate of				Reg. N	20	12	01	155
ı	Physicia Medic		1. Decedent's Name		co Bloomer				2. Date of Death Month Day 201			2 ∕ear	3. Time	of Death			
	Examir		4a. Facility Name (if Howard (pital		4b. City, Town	or Locatio			4	c. County	of Death vard		
唐	Funeral Director		5. Social Security No. 219–22–38		6. Sex 1 X M 2 □ I	"	e (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Day		der 24 Hrs. Min.	8. Date of Bir (Month, Da	ıy, Year)		9. Birthp Coun	place (State try)	e or Foreign
	ow st	ı.	Usual Residence of					Town or Loc	cation			05/03/	03/1928			MI Od. Inside	
	Aarylar 8a-f sh tified a	Funeral Director	MD	Howa	rd		Too. Oity,	Glen									es 2 X No
	h the had or 2 be no	al Di	10e. Street and Nun						10f. Zip Code				10g. Citizen of What Country			-	
	ith wit ms 23 must	ner		Roxbur			Evenie II O	140.1/	2173		Origin? (Co.	noify Van ar Na		nited			
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		Armed	Forces? s 2 ½ Give	Ever in U.S. No		Vas Decedent of Yes, specify Cu ☐ Yes 2X1			Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White			
5-0	2 hours	plete	(Spe		it's Education		- 1		lent's Usual Occ		ast of work	ina	16b.	Kind of Bu	-		
21215-0036	within 72 giene. ner than t, the Me	Completed	Elementary/Seco			(1-4 or 5	5+)	Ìife. D	NOT use retire	d)	031 07 WOIN			Telep	ohone	e Comp	pany
Maryland	d be filed dental Hy irked oth tic even	To Be	17. Father's Name (i							1		e (First, Middle, Porter	Maider	n Surname)		
2	12 should alth and N		19a. Informant's Na Nancy I		ip (Type, Print) mer – Wi	fe			g Address (Stree			al Route Numbe	er, City or Town, State, Zip Code)				
Baltimore,	a. O 4= 1			Cremation	3 🗌 Removal fro	m State	ce	metery, cren	sition (Name of natory or other p	lace)		Date		Location -			
altin	in a rain a		21. Ignature of Fur	5 Other (S	_	2	Mead		ge Mem. Name and Add	ress of Fac		23/2012 erry H.	_	Elkr: zke!s			TH Inc.
B	Dep Imp		M	July	may				112 old		-10						
	nysician/		shock, or hear Immediate Cause (disease or condition	t failure. List o Final	complications that	each line	d the death. e.		r the mode of d	ving, such	as cardiac (or respiratory ar	rest,			Approxim Interval B Onset and	Between
	Medical Examiner	Ļ	resulting in death) Sequentially list co	nditions	Due		a conseque										
8	uted d ansit	Examiner	if any, leading to im cause. Enter Under Cause (Disease of that initiated events	imediate rlying injury	Due	o (or as	a conseque	ence of):									
	ath certificate be executed attending physician and for use as the burial-transit		resulting in death) I		d.	o (or as	a conseque	ence of):									
. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours affer death. 24 hours affer death affer this certificate has been signed by the attending physici trenyral Director. After this certificate has been signed by the attending physici stely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		/e Birth egnant a		death 3	Ectopic pregna Other (specify)					23d. Dat Mo	e of deliventh	ery Day	Year
s, P.O.	requires that the dec been signed by the should be detached	d by P	Part II. Other signif		ns contributing to		out not resu	Iting in the u	nderlying cause	given in Pa	art I.				-	ne cause of bably 4[f death?
Records,	The law requate has beer page 2 shou	Completed by		OPD								24a. Was		P		psy finding mpletion o	s available f cause of
E R	ician: The certificate rector, pag		25. Was case referre		ryopat	hot			26	Plane of D	eath (Chec	1 Yes			Yes	2 40	
of Vital	lysicia is cert direct	To Be	examiner?		Hospital:	Inpati	ient 2 🗆 E	R/Outpatien	Ic	ther'		ome 5 Aesi	dence	6 □ Othe	er (Specify)	
on of	nding Ph tth. : After thi e funeral		27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pendir Investi	g (M	te of inju onth, Da	y, Year)	28b. Time of injury				28d. Describe t					
Division	ne Hospital or Attendir n 24 hours after death. te Funeral Director: Af oletely filled in by the fu	I Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be 28e. Pla		ury - At hon c. (Specify)	ne, farm, stre	eet, factory, offic	Э		28f. Location (\$ City or Tov			er or Rural	Route Nui	mber,
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medical	(Check 2		Physician: To the xaminer: On the l Nurse Practition	pasis of e	examination	and/or invest	igation, in my op	nion, death	occurred a	t the time, date a	and plac	ce, and due	e to the ca	use(s) and r	manner stated.
	Vith Coal		29b. Signature and	title of certifier	A	N	\ .D.			6651)			-	ate signed	(Month	12 ^{Year)}	
	8		30. Name and addre	ess of person	M.D.				rint)								
	Sta Registra		31. Date filed (Monti	7, Day, Year)	h 32	Registr	ar's Signatu	ire									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	Otato of Marylan		tificate of D			Reg. No.			
PI	hysicia Medic	n/	1. Decedent's Name (First, Middle, L PLORIN	N	ea i	27		2. Dale of De	ath (72)	=	3. Time of Batty	
) E	Examin		4a. Facility Name (if not institution, g			4b. City, Town, or	Location of Dea	th	4c. County of	Death ltim c	nre	
Fu	uneral		42 Cedarmere 5. Social Security Number 6	Sex 7. Age (In yrs. Ia	ıst birthday)	If Under 1 Year	If Under 24 Hrs		th s	9. Birthpla	ace (State or Foreign	
	rector		220-22-2853	1 □ M 2 🔀 F 83	Yrs.	Months Days	Hours Min	,	6, 1928	Country	yland	
and	show	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10	d. Inside City Limits	
Maryla	28a-f s	Director	MD Balt	imore	iwO	ngs Mills	5				1 ☐ Yes 2 🗷 No	
th the	sa or s		10e. Street and Number	D 1		10f. Zip Code	1.7		10g. Citizen of Wh		y?	
ath wil	ems 2	Funeral	42 Cedarmere	12. Was Decedent Ever in U.S	13.	2113 Was Decedent of Hi		Specify Yes or No-			n Indian.	
21215-0036 within 72 hours after de giene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces?		f Yes, specify Cuba 1 ☐ Yes 2X No	n, Mexican, Puer	rto Rićan, etc.)		White, et Whi	c.	
15-(ı "natı ledica	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occupa kind of work done of	ation Juring most of wo	orking	16b. Kind of Busi	ness/Indu	ıstry	
vithin jiene.	the M		Elementary/Secondary (0-12)	College (1-4 or 5+)		O NOT use retired) lousewife			Own Ho	ome		
nd filed v	d othe		17. Father's Name (First, Middle, Las	t)			18. Mother's Na	ame (First, Middle,	Maiden Sumame)			
ya uld be I Ment	narke natic e	٩		ernon Hafele					ssey			
Mal 2 shoi th and	27 is n traun	i	19a. Informant's Name/Relationship Jennifer Ann Br						er, City or Town, State			
1 and 1 Heal	item		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date	20c. Location - C			
Page	ant: If ury or		1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	- Nellioval licili otate		natory or other plac		19/12	Hampstea	ad, N	Maryland	
Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy	Import any inji once.		21. Signature of Fiftheral Service Lice			2. Name and Addres			Reistersto erstown, l		Road 21136	
M	ician edical miner		23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	Λ /	ARC	er the mode of dying		ac or respiratory ar	rest,		Approximate Interval Between Onset and Death	
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ence of):							
St. Ba	ransit	Examiner	Cause (Disease or injury that initiated events	C								
e exec	physician and s the burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):							
8760 ifficate be	g physi as the l	Medical		d				-				
ox 6	attendir for use	=	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No g ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Fete 4 ☐ Pregnant at time of c	death 3	Ectopic pregnand Other (specify)	;y		23d. Date Mont		y Day Year	
S, P.O.	been signed by the a should be detached	þ	Part II. Other significant conditions Lung and	Contributing to death but not res	ulting in the	Inderlying cause give	ven in Part I.		obacco use contrib		cause of death?	
Division of Vital Records, lal or Attending Physician: The law requires after death.	nis certificate has been il director, page 2 shoul	Completed	primary	nod ide	n kik	ned		24a. Was auto perfo	psy pri ormed? de	or to com ath?	sy findings available pletion of cause of	
6	tificate tor, pa		25. Was case referred to medical	1	-	26. PI	ace of Death (Ch		2 No. 1	Yes 2	2 L No	
Vita hysici	nis cer Il direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2			er: 4 🗌 Nursing	Home 5 Resi	dence 6 Other	(Specify)		
of Cing P	nera	ate:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time o injury	work		28d. Describe	how injury occurred			
/iSiOI r Attend ter deatl	rector: .	Certificate:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determine	t be 28e Place of Injury - At he			res 2 🗆 NO	28f. Location (eet and Number or Rural Route Number, State)		
Div pital o	eral Di		on ourse 4 Flouritains	husisia a To the heat of my know	la dea death	and urred at the time	a data and place			r on otator	4	
the Hosp hin 24 ho	To the Funeral Director: Af completely filled in by the fu	Medical	(Check 2 Medical Exaconly one) 3 Certifying N	hysician: To the best of my know miner: On the basis of examination urse Practitioner: To the best of r	and/or inves	stigation, in my opinion, death occurred at t	on, death occurre the time, date and	d at the time, date	and place, and due t the cause(s) and ma	o the caus	se(s) and manner stated. ated.	
o Po Witi	₽ ö		29b. Signature and tile of contifu	Dh ~	MY	2 29c. License	number 5	2	29d Date signed (Month, D	ay, Year) 20/2	
	6		30. Name and address of person when	o completed cause of death (Item	23a) (Type,	Print)	_Blue	d Oler	2 Dare	nie	20/2	
F	Stat Registra	Le	31. Date filed (Month, Day, Year) - JAN 2. 0	32. Registrar's Signa	ture							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20c per fh g923 1-20-12 vt
State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2012 Month JANUARY BOGDONOFF 7:25P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FUTURECARE CHERRYWOOD REISTERSTOWN BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 205-14-5736 1 X M 2 D F 100 09/15/1911 RUSSIA Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2218 RIDGE ROAD 21136 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give 3 X Widowed 4 Divorced WHITE Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 GROCER OWNER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ABRAHAM BOGDONOFF FANNIE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2218 RIDGE ROAD, REISTERSTOWN, MD 21136 ARLENE PERLOFF / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Collingdale, PA 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) LEBANON CEMETERY 01/20/2012 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ISSASE disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Box 68760 IE EEMALE asn yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by C'ARSTOMYO PATMY Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? DEMENTIA 24a. Was an Physician: The law autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural iniury 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 2 🗌 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R08885Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 51 2835 Smith Ausnus "203 Barrinore, Mary Inna 21209 DIAMOND

DHMH 17 Rev 06-2011

State Registr<u>ar</u> 31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15 t, ha Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 401 E. 25th St. N/A Apt. Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Hours Days Min (Month, Day, Year) Country 218-28-3220 **Director** 1 🗆 M 2 🗙 F 79 11/25/1932 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director N/A 1 XYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 401 E. 25th St. 21218 Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 2 X No Maryland 21215-0036 1 🗆 Yes 2 No Specify If Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) 12th <u>Nursing Assistant</u> N/ABe 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) ပ William Lewis Lillian Slocum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) \$herri Taylor-Daughter 5619 Frankford Ave. Baltimore, MD 21206 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)

Garrison Forest 1 X Burial 2 Cremation 3 Removal from State 1/23/2012 OwingsMills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility ${\sf March}\;\;{\sf F/H}\;\;{\sf East}\;\;{\sf 1101}\;\;{\sf E}$. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami burial-transit Due to (or as a consequence of) resulting in death) Last the attending physician Be Completed by Physician/Medical or Attending Physician; The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attention to the Funeral Director after this certificate has been signed by the attention to the funeral director, page 2 should be detached for the funeral director. in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 💆 No ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature ar 29c. License number 2

DHMH 17 Rev 06-2011

State Registrar on who completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Leon Coley TON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Union Memorial Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 X M 2 □ F Months Days Hours 1 278 7 4 94 4 216-42-5506 67 N.C **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 ☐ No MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3745 Elmora Ave. 21213 USA death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married "natural", or à 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed nand Mental H Betty Alston Lewis Coley . Page 1 and 2 should tment of Health and M tant: If item 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3745 Elmora Ave. Baltimore, MD 21213 Carrie Coley- Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Druid Ridge Cemt. 1/21/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H East 1101 E. 21. Signature of Funeral Service Licen North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury 18855F attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 No sate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Hospital or Attending Physician: The law requires to hours after death.
Funeral Director: After this certificate has been sign 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) completed filled in by the funeral director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 XInpatient 2 ER/Outpatient 3 DOA မ nner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

24 hours a the within To the

> State Registrar

Medical

29a. Certifier

29b. Signature

(Check

only one)

30. Name and address of

31. Date filed (Month, Day, Year)

JAN 2

DHMH 17 Rev 7/2009

rson who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00020111

a) (Type, Print)
LON MEMORIBE HOSPITH 3DET, Or)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 17, 2012 10:15 a^M January Wallace Reed Cochran Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Senator Bob Hooper House Forest Hill Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, Year) Days Hours Director 220-22-8742 1 M M 2 F 1927 North Carolina July 12, 84 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City, Town or Location Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 ☐ Yes 2 🗷 No Maryland Harford Street 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21154 1129 Taylor Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by 201 21215-0036 1 ☐ Yes 2 🙀 No Specify: White 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunications HVAC Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 3altimore, Maryland 17. Father's Name (First, Middle, Last) ဂ Andrew Mack Cochran Anna (nmn) Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4850 Delta Road, Delta, PA 17314 Donna C. Whiteford / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Bel Air Memorial Gdn. 1-20-12 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, 3 on ture of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to or as a consequence of If any, leading to in medicause. Enter Underlying Cause (Disease or injury burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be excuithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Alatural
2 Accident
3 Suicide
4 Homicide work? 5 Pending 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Cortifying Nurse Practitioner To the best of my knowledge, death, occurred at the time, date and plans, and due to the 29d. Date signed (Month, Day, Year) 29b. Signature and of death (Item_23a) (Type, Print) 30. Name and 170

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2012 Physician/ 16, 10:50P M III Cleckley Samuel Jan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** (Month, Day Year 12, , 1961 Days Maryland 1 🔀 M 2 🗆 F Months Hours Min. May 50 **Director** 220-80-9441 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral U.S.A. 727 N. Collington Avenue 21205 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced . Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Medical" Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) lementary/Seconday (0-12) College (1-4 or 5+) n/a Disabled 11th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosetta Hudson Cleckley Jr. Samuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5963 Schering Rd, Baltimore, MD 21206 Victoria Beard (niece) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any Injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1/19 On-Site Cremation Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Joseph H. Brown Jr. Funeral Home, 2140 N. Fulton Ave, Baltimore, MD Signature of Funeral Service Licenses PA 21217 leams 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ear. Medical to (or as a consequence of): Examiner vascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the at Id be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably Division of Vital Records, been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work?
1 Yes 2 No iniury 5 Pending Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 3 🗆 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

31. Date filed (Month, Day, Year)

12-00451

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

yler James Cordr	-	State State	e of Maryla		artment of rtificate of		and	Menta	I Hygiene	Reg. No		2 01102
Physician		egistrar . Decedent's Name (First, Middle,L	_						2. Date of D	eath Day	Year	3. Time of Death 0807 hrs
Medical Examine	r	-1	ordrey			h City To	m or lo	ocation of D	January	16, 20	012 4c. County of Death	0807 Hrs
		a. Facility Name (if not institution, g		imber)	ľ	Annap		Joan Oli D	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Anne Arundel	
Funeral		5. Social Security Number 6.	Sex	7. Age (In yrs. I		If Under		If Under 2			M/DD/YYYY) 9. Birt Foreig	n
Director	ı	215–33–9163	M 2 F	25	O Yrs.	Months	Days	Hours	May May	4, 1	986 co	ıntry) MD
any	_	Jsual Residence of Decedent 10a, State 10b, County		10c. City,	Town or Location	on						10d. Inside City Limits
		MD Prince (George's	Lau	cel							1 Yes 2 No
the Maryland nor 28a-f show iffied at once.	3	0e. Street and Number	al -			10f. Zip 0				10g. C	Citizen of What Cour	ntry?
eath with the Maryland fems 23a or 28a-f sho ust be notified at once	_	332A Montgomery		- d- t Fran in II	S 42 Was			anic Origin	? (Specify Yes or	L		can Indian, Black,
r death with or items 23 must be no		11. Maritel Status 1 X Never Married 2 Marri	ied Armed F	cedent Ever in U orces? 2 X No	.S. If Ye	es, specify	Cuban, I	Mexican, P	uerto Rican, etc.)	140	White, etc.	
	֡֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֜֟֝֟֝֟֜֟֝֟֜֟֝֟֝֟֝֟֜֟֝֟֜֟֟֝	3 Widowed 4 Divorce	1 Yes ced if Yes, Give Yes or Dates:			Yes 2	_				Specify: Whit	
hours Frami		15. Decedent's Education (Specify Elementary/Secondary (0-12)		de completed) 1-4 or 5+)	16a. Decedent during mo	t's Usual O ost of worki	ccupation ng life. D	n (Give kin OO NOT us	d of work done e retired)	165	o. Kind of Business/I	ndustry
hin 72 than than than dical	neteldilloo	Elementary/Secondary (0-12)	4	1-70101)	Compute	er Pro	_				Mars Laboi	ratory
	5	17. Father's Name (First, Middle, La Keith A. Cordre	ast)						Name (First, Midd een H. H			
Z = 2 2 5 1 6		19a. Informant's Name/Relationship		-	19b. Mailing	Address					City or Town, State	, Zip Code)
MD 21 2 should 1 2 should 1 27 is man martic cv		Kathleen H. Harr	rington/								nd 21822	
or Heal		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal f	rom State	Place of Dispos crematory or oth	er place)		1	Date		c. Location - City or	
Baltimore, permit. Pages 1 as Department of He Important: If ite injury or other the	Ц	4 Donation 5 Other Spec 21. Signature of Funeral Service Lice	cify:	Fi	1 - 1/2				01/20/1		Woodbine,	
Bal permit Depar Impor			// //	MO12	[Go]	ing H	ome i	Crema Heckr	tion Ser	Vice	e P.O. Bo	ox 784 le MD 21029
Physician	1	23a. Part I. Enter the lisease, or confailure. List my one cause or	emplications that on each line.	caused the death	n. Do not enter th	ne mode of	dying, s	uch as card	diac or respiratory	arrest, s	shock, or heart	Detweet Check and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hypotherm									Death
		Sequentially list conditions,	b.	a consequence o	эт):							
		if any, leading to immediate cause. Enter Underlying Cause		a consequence	of):							
=	Εŀ	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	of):							
ta and ecu		UNPENDED	d									
		IF FEMALE:		outcome of preg	nancy					1	23d. Date of deliver	
Sox 6876(leath certificate e attending phys for use as the b		3b. Was decedent pregnant in the past 12 months?	1 Live	birth nant at time of d		tal death her (Speci	3	Ectopic p	regnancy		Month I	Day Year
Box 6876(e death certificate the attending phy ed for use as the b	Pnysician/M	1 Yes 2 No 9 Unkno	own 9 Unkr	nown	ەن مان مان مان مان مان مان مان مان مان ما							
P.O. that the med by the detache	5	Part II. Other significant condition	ns contributing	to death but not	resulting in the u	ınderlying	cause giv	ven in Part				the cause of death? bably 4 Unknown
duires t quires t en sign	9								24a. V	Vas an	24b. Were au	utopsy findings available
Vital Records, system: The law requirements his certificate has been signerery, page 2 should	Completed								— I_p	utopsy erformed es 2		completion of cause of
tal Recian: The certificate ector, pag		25. Was case referred to medical				2	6.Place	of Death (C	theck only one)	63 2		
Vita	900	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient		<i>"</i> ·		Nursing Home 5		sidence 6 Othe	r: Scene
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the safter death. J Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detach.		27. Manner of Death 1 Natural 5 Pendin	E-CYYRY	e of Injury th, Day,Year) D:	28b. Time of I FOUND:	njury 2		vatWork? es 2. ✔ N	Subject	was in	injury occurred sailboat that ca	apsized in
isio		2 Accident Investi	gation Jan 16	, 2012 ce of Injury - At I	0756 hrs nome, farm, stre	et, factory,			28f. Locati	on (Stree	et and Number or Re	ural Route Number, City
Div	Certification:	4 Homicide	ined (Specify	Bay					Chesapea		, none, MD	
		29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the be	est of my knowle	dge, death occu and/or investiga	rred at the tion, in my	time, dat opinion,	e and place death occu	e, and due to the urred at the time,	cause(s) date and) and manner as sta i place, and due to ti	ted. ne cause(s)
To tl withi To tl comp	Medical	29b. Signature and title of certifier	and manner		A			number			9d. Date signed (Mo	
		Tield Date	terle	el	5		O.C.N	M.E.		J	lanuary 17, 201	2
6 V	-	30. Name and address of person w	no completed ca	use of death (Ite	m 23a)	/ Raltin	ore St	reet Ro	Itimore MD 3	1223		
Sta	to	Victor Weedn MD JD					-	ieel, Da				
Sta Registr	ar	31. Date filed (Month, Day Year)	1012 De	Registrar's Signa	J. Jan	Kal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Physician/ 2012 18, Clark Ε. Jan. 2:30 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care Health Services Towson 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Months Days Hours Min. Nonth, Day, Year) 115/1932 Maryland Director 215-30-9046 79 Yrs Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No MD Baltimore Towson 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 509 E. Joppa Road 21286 U.S.A. 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 11. Marital Status þ 1x Never Married 2 ☐ Married 1 Yes 2 X No If Yes, Give Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Divorced 4 Divorced oe filed wn. *rtal Hygiene *ther than "natu. *a Medical Ey 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygient Important: If item 27 is marked other than any injury or other traumant. Clerk Hecht Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Clark Carrie Morton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2323 Kateland Ct., Abingdon, MD 21009 Wendell Blue (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20 On-Site Cremation Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Home, PA 21. Signature of Funeral Service Licensee Joseph H. Brown, Jr. camo 2140 N. Fulton Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/)ement19 disease or condition resulting in death) Medical Examiner erebral Vuscular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year signed by the a d be detached f 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page 2 performe 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be funeral director examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural 5 Pending thin 24 hours after death.

the Funeral Director: After mpleted filled in by the fun 1 Yes 2 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

ac

2012

Jason 31. Date filed (Month, Day, Year) 701

NorTh

32. Registrar's Signature

Box 68760

P.0.

Records,

of Vital

Division

Charles St Suite 4105 Tourson MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01/09 2012 Physician/ 10:10 PM Theresa V. Demski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1707 Morning Brook Drive Harford Forest Hill 8. Date of Birth 9. Birthplace (State or Foreign Country) MD er 1 Year If Under 24 Hrs. 6. Sex Age (In vrs. last birthday) **Funeral** 212-30-9998 Days Min. 01/06/1934 78 Months Hours 1 □ M 2 😾 F Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must ha matter and 10b. County 10a. State 10c. City, Town or Location **Funeral Director** MD Harford Forest Hill 1 Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21050 1707 Morning Brook Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify:White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Western Electric assembler Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Grande 2 Gimbatista Varallo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Morning Brook Dr. Forest Hill, MD 21050 19a. Informant's Name/Relationship (Type, Print) Fredrick V. Demski Jr.- Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1/13/2012 Gardens cremetom graften place) Rosedale, MD 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 610 W. MacPhail Rd. Bel Air, MD 21014 Inc. 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Deal 23a. Part 1. Enter b. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final month Physician/ disease or condition resulting in death) Medical Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury by Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death 9 Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perforn 2 No this certificate Yes 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital funeral director. Be examiner? 2 700 Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 2 🗆 No 1 🗌 Yes within 24 hours after death. To the Funeral Director: A Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier ellar celaun ru 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUASALAM. 510 UPPER 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JAN 2 0 2012 Registrar

DHMH 17 Rev 7/2009

12-00232	
Anna Dorsey	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nna Dorsey		State of Maryland / Department of H	lealth and Mental H	vaiene	2012	01165
		1- For State Certificate of E				. 01100
Physici		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	Day Year	3. Time of Death
edical Exami	ner	I FILLIA DUI DET		January 8, 2	2012	1830 hrs
			City, Town, or Location of Death Baltimore		4c. County of Death	
			If Under 1 Year If Under 24Hrs	9 Date of Birth	(MM/DD/YYYY) 9. Birth	onlace (State or
Funeral Director		- 7	Months Days Hours Min.		Foreign	1
Director		216-32-9758 1 M 2 XF 79 Yrs.		1/4/1	1932 000	intry) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
. .	L	MD N/A Baltimo	1.0			1 Yes 2 No
ırylan ta-f si	g	10e. Street and Number	Of. Zip Code	100	g. Citizen of What Coun	try?
he Mariner 2	Director	3119 Barclay St.	21218		USA	
with t		11. Marital Status / 12, Was Decedent Ever in U.S. 13. Was D	ecedent of Hispanic Origin? (Sp		14. Race - Americ	an Indian, Black,
death r iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes,	specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after all", o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Ye	es 2 X No specify:		Specify: Blo	
natur Exam		during most	Usual Occupation (Give kind of v of working life. DO NOT use reti		16b. Kind of Business/Ir	ndustry
16 n 72 l	olet	Elementary/Secondary (0-12) College (1-4 or 5+)	Lds		School S	ustem
5-0036 iled within 7 Hygiene. d other than	Completed	17. Father's Name (First, Middle, Last)	todian 18.Mother's Name	(First Middle Ma		J-0
215-0036 be filed within 72 hours ntal Hygiene. ked other than "natur ent, the Medical Exam	Be C	John Banks	Ann		ewis	
D 2121 should be fil and Mental I 7 is marked natic event,	ToB	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	ddress (Street and Number or F	Rural Route Numb	er, City or Town, State,	Zip Code)
', MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death with the Maryland err 77 is marked other than "natural", or items 23a or 28a-f she braumatic event, the Medical Examiner must be notified at once	T	Antoineffe Harris-Daughter 2444	Brentwood A	re. Bal.	FU, MO 2	1218
	М	20a. Method of Disposition 20b. Place of Disposition crematory or other		Date	20c. Location - City or	Fown, State
Baltimore, permit. Pages 1 at Department of He Important: If ite		1 Name 1 Name 2 Cremation 3 Name Removal from State Crematory or other 4 Donation 5 Other Specify:	orial PK. 1/1	4/2012	Randallste	SWEIMO
Baltir permit. I Departme Importa injury or		21. Signature of Juneral Service Licensee 22. Nam	ne and Address of Facility	with Elil	East 1101 E.	North Are
	6 18	Stimetto Kymes Bal	to: MD 21202			
Physician		23a. Part I. Enter the disease, or comprications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac of	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
. Medical ≛xaminer	1	Immediate Cause (Final disease a. Complications of Urina	ary Tract Infec	tion		Death
=xa		or condition resulting in death) Due to (or as a consequence of):				
,	5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	miner	cause. Enter Underlying Cause				
igi sa ka	Exa	events resulting in death) Last				
executed an and al - transit	lical	M UNPENDED X AMENDED 23a, pt. II, 27, per	me. 0926 4-9-12) cm		
41 77 77	edi	the state of the s	12.WS #19a.per	h.g926	4-12-12 sm 23d. Date of delivery	
Box 68760, edeath certificate be the attending physici of for use as the buri-	3	IF FEMALE: 23b. If yes, ourcome of pregnancy 1 Live birth 2 Fetal	death 3 Ectopic pregna	ancy		ay Year
th cer trendi	icia	Pregnant at time of death 5 Other	(Specify)			
Bo le dea the a	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown		Too Did tob	acco use contribute to t	he source of death?
P.O.	by P	Part II. Other significant conditions contributing to death but not resulting in the und		4 🗀 v	2 ✓ No 3 Prob	
S, P.C juires that an signed Id be deta	Pe	Diabetes Mellitus, Hypertension, End St	<u>age Renal Disea</u>	Se 24a. Was ar		opsy findings available
cord law req has bee 2 shou	plet	Rheumatoid Arthritis		autops	y prior to c	ompletion of cause of
Records, The law require	Completed			1 ✓ Yes 2		s 2 No
tal Recian: The certificate ector, page	Bec	25. Was case referred to medical examiner?	26.Place of Death (Check			
of Vital ng Physician After this certi	70	1 Yes 2 No Inpatient 2 ER/Outpatient 3			tesidence 6 Other	
n of ling Pl After funera	Ë	27. Manner of Death 1 X Natural 5 Panding 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe ho	ow injury occurred	
sior ttend death ctor: y the	äţi	2 Accident Investigation	1 Yes 2 No	001	- d N - b D	- Dougla Months City
Division tal or Attendi rs after death. al Director:	Certification:	3 Suicide 6 Could not be determined (Specify)	factory, office building, etc.	or Town, Sta	reet and Number or Rui ate)	al Route Number, City
fi e c pi		4 Homicide	71		(-)	
To the Hos within 24 h To the Fun completely	ca	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred (Check only one) Wedical Examiner: On the basis of examination and/or investigation				
To t	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	
,	_	(M	O.C.M.E.		January 9, 2012	
M.		200 Name and address of possess the consistent asing of death (New 220)	1			
Y		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W	/. Baltimore Street, Baltir	nore, MD 212	223	
	tate					
Regis		IANO A COLO				
DHMH 17 Rev 1/2	001	ORIGINAL				
OCME 2006		COME				

DHMH 17 Rev 1/2001 OCME 2006

COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Day 11, 2012 Physician/ 3:00 AM LaVerne Daughtry Geneva Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death County of Death Prince Georges Bowie Larkin Chase Nursing Center 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2**X** F (Month, Day, 05/04 Virginia Director 227-40-8808 81 1930 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits death with the Maryland Director Temple Hills PG 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20748 4318 Delmar Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 X No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Specify: Black "natural", 3 ₩ Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Private Food Services Manager 12+h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Minnie Boyd Richard Dancy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 207011622 Golf Course Drive; Mitchellville, MD 19a. Informant's Name/Relationship (Type, Print) Montez D. Taylor-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 X Removal from State Jarratt, Virginia Daughtry Cemetery 1/17/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, MD 20748 21. Sign Fig of Funeral Service Licens Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER nysician/ 01 70N disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Jause (Disease or imjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Month 5 Other (specify) par 9 Unknown 9 Unknown P.O. been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No director, page 2 death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🂢 No Be 26. Place of Death (Check only one) Hospital: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 XNatural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🛮 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and addre

Adebowale

6201 N Greenbelt Road; Ste#U-15 College Park,

20740

ho completed cause of death (Item 23a) (Type, Print)

32. Registrar's signature

MD

ayi,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 17,2012 Year Physician/ 9:08P M January William Edwards Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balto. Nottingham 4107 Kahlston Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** Months Days 8-29-192883 Maryland Director 83 215-24-6857 Yrs 10d. Inside City Limits 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Nottingham Md. Balto 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21236 USA 4107 Kahlston road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates. 1951-1952 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Westinghouse Electric Salesman 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Dorsie Byrd George R. Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4107 Kahlston Road Nottingham, Md,. 21236 Spouse Joan Edwards 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1-20-2012 Parkville, Md. Parkwood 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Eugeral Service License Nottingham, Md. 21236 9705 Belair Road 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final 162hainers GR. Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tranthat initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Great Live Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 10 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Tyes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After 1 Natural 5 Pending injury 1 Tes 2 No n 24 hours after warner A re Funeral Director: A Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

within 2 To the

only one

29b. Signature and title of certifier

32. Registra s Signa

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 121 Chard J - 60055, 40, 50, to 200, 4724 Comphell Blud., Whik Black Md 21236

0018718

29d. Date signed (Month, Day, Year)

JANUAY 18, 20/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 10 Physician/ Month 38 AM Harry Joseph Foell, Jr. Medical Januar 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BAltimore 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours Director 170-22-8644 1**X**] M 2 □ F 14, 1929 82 PA Aug. 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Harford 1 X Yes 2 No MD Bel Air 10e. Street and Number 10g. Citizen of What Country? Funeral 1311 Scottsdale Drive Unit E 21015 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1945 Completed by 1 Never Married 2 X Married 1 Yes 2X No Specify. 3 Widowed 4 Divorced White 1949 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Mechanical Manufacturing Engineer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Joseph Foell, Sr. Mary M. Dederer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Bettie S. Foell/Wife Page 1 and 2 1311 Scottsdale Dr. Unit E Bel Air, MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan^{Date} 13, cemetery crematory or other place)
Dulaney Valley
Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JJ Hartenstein Mortuary, 24 N. Second St. New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Medical resulting in death) Examiner Securettally list conditions Physician/Medical Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician that the death certificate be P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 N 1 Yes 2 \square No Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 01-10-2012 who completed cause of death (Item 23a) (Type, Print) Pa

からか

Registrar

DHMH 17 Rev 06-2011

State

12-00436 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Leonard Thomas Fazio State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day January 15, 2012 **Medical Examiner** 1631 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Route 30 south of Trenton Mill Road Carroll Hampstead 8. Date of 8irth (MM/DD/YYYY) 9. 8irthplace (State or **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Days Months Hours Director Country) France 1X M 2 F 215-92-4107 48 03-15-1963 Usual Residence of Decedent 10a, State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 X No 28a-f show other than "natural", nr items 23a or 28a-f sho the Medical Examiner must be notified at once. Carrol1 Manchester Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3734 Millers Station Road 21102 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes f Yes, Give Yeer or Dates: within 72 hours after 3 Widowed 4 Divorced 1 Yes 2 X No specify: Specify: White à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77. Department of Health and Mental Hygiene. Important: If item 27 is marked other than Stone Shooters, Inc. Special Equipment Operator 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) other traumatic event, BB Thomas Edward Fazio Francoise Guerin ဥ 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5258 Misty MOrning Dr. Las Vegas, NV 89118 Francoise Fazio Timmons (mother) 20a. Method of Disposition 20b, Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Donation 5 Other Specify 1-23-2012 Hampstead, MD Hampstead Cemetery 21. Signature of Fundral Service Licensee 22. Name and Address of Facility ELINE FUNERAL HOME J. Wayne Osterling 11824 Reisterstown Rd. Reisterstown, MD 21136 he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. en Onset and /Medical a. Torso Injuries Death Immediate Cause (Final disease £xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - transit Physician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed I hould be deta ğ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other 1 Nursing Home 5 Residence 6 🗸 Other: Scene 2 ER/Outpatient 3 this No 1 Yes 28a. Date of Injury 28d. Describe how injury occurred After 27, Manner of Death 28b. Time of Injury 8c. Injury at Work? Jan 15, 2012 Subject operator of motorcycle left roadway within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Natural 1601 hrs Pending 1 Yes 2 ✔ No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be To the Hospital or or Town, State) Route 30 south of Trenton Mill Road, Hampstead, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 16, 2012

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Melissa Brassell, MD

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

trar's Signature

ORIGINAL

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) January 15, 2012 Year Physician/ 6:55A. M Foard Suzanne Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balto. Towson Gilchrist Hospice 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** CouMaryland Hours Days 1 🗆 M 2 🔀 F July 12 , 1941 216-38-3204 70 **Director** Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Nottingham Balto. Md. 1 Yes X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral uSA 21236 4532 Ambermill Road 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, et-1 Never Married 2 Married 1 Yes 2 þ White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 □ Divorced Year or Dates 16b. Kind of Business Industry 16a Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trailmetin. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Baltimore County Schools Educator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Ruth Kermis Angelo Franco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 302 S. Taylor Avenue Essex, Md. 21221 Jacqueline Baranowski DTR 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Gardens of Faith 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1-21-2012 Balto. Md. 4 Donation 5 Other (Specify) 21. Signatur of unergl Service Licensee 22. Name and Address of Facility Schimunek Funeral Home,, Inc Nottingham, Md. 9705 Belair Road art 1. Soled the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Elbysacing. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>호</u> 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Yes 2 No Yes 2 🔽 After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital 1 🗌 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred completed filled in by the funeral 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certific 29d. Date signed (Month, Day, Year, 71040 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

State Registrar 32. Registra s Sign

SULTZUOS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 Joseph Matthew Fuka 12:00 PM January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Fallston 1708 Abelia Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Months Director 1 🔀 M 2 🗆 F 98 9/11/1913 216-09-5158 Belcamp, MD Yrs ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State Director MD Harford Fallston 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21047 USA 1708 Abelia Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify "natural", White Completed 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Yrs College (1-4 or 5+) Steel Worker Armco Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Frank Fuka Sophie Bartusek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1708 Abelia Rd., Fallston, MD 21047 Mary Fuka 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State Gardens of Faith 1/19/2012 Baltimore, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home, Inc. Funeral Service Signatur 610 W. MacPhail Rd., Bel Air, MD 21014 Approximate Interval Between Onset and Death . Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the a I Inknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performe 2 No 1 ☐ Yes 2 ☐ No certificate Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: 28a. Date of injury (Month, Day, Year) iniury 5 Pending Natural 2 🗌 No s after death. Investigation Accident filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying the Examiner: To the best of properties and manner as stated. 29a. Certifier completely (Check Certifying Nurse Eractitioner To the best of within 2 To the 29b Signature and the of certific 29d. Date signed (Month, Day, Year) 29c. License number 2012

State Registrar 31. Date filed (Month, Day, Year

DHMH 17 Rev 06-2011

who completed cause of deal (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 3, Physician/ 2012 Nicholas 20:16M Gragory Forrest January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2304 Rogate Circle, #302 Baltimore Woodlawn If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JUL 16, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Director 1989 255-71-93 ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Baltimore Woodlawn MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Completed by Funeral 2304 Rogate Circle, 21244 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Deceded...
Armed Forces?

1 Ves 2 No 2008 -Black, White, etc. 1 X Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Caucasian 3 Widowed 4 Divorced Year or Dates. Present 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Sailor -Enlisted U.S. Navy Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic v Stephen Joseph Forrest Laura Kay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49783 Father Stephen J. Forrest S.Ridge Rd., Sault Sainte Marie. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 01/20/2012 Sault Ste. Marie, MI 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Thibadeau Mortuary Service, pa M00956 Ave. Gaithersburg, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) shot wound to head Physician/ a Suicide Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death 5 Other (specify) signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No is certificate his director, page Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after deaun. **e Funeral Director.** After this of the funeral di Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred SELF inflicted 2016 P 5 Pending 1
Natural 01/13/2012 Gunshot wound To head M Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28. Location (Street and Number or Rural Route Number, City or Town, State) 2304 Roga FeC. VCLE #303 U) NdSoR, MV 21244 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined #303 Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the dause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18,2012 January 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) 9 31. Date filed (Month, Day, Year State Registrar

2016

2015

0

holas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 1 Day Physician/ Ray Anthony Gray 10:43 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7932 Langdon Lane N/A Baltimore 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours 225-74-0934 Director 1 X M 2 □ F 6/5/1953 58 Yrs VA Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a State 10c. City, Town or Location Director N/A notified MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ral", or items 23a or Examiner must be Funeral 7932 Langdon Lane 21206 USA · death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12 Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🗙 No Specify: If Yes, Give Year or Dates Black "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) event, the 12th Iron Worker Local Union #16 Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Temple Benjamin Gray Kathleen Ida Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Gray - Wife 7932 Langdon Lane Baltimnore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place, 1/21/2012 Dunnsville, VA Angel Visit Cemt. 21. Signature of up ral Service Licensee 22. Name and Address of Facility March F/H East. 1101 E. Tim Ave. Baltimore, MD 21202 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pancreatic Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death signed by the at id be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed plnoys peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy performed? 1 Yes 2 No this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending iniury Natural Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 📂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

only one

31. Date filed (Month

29b. Signature and title of certifier

Luis

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401

Diaz.

2°0 2012

29c. License number

Broadway Baltimore, MD 21231

00057984

29d. Date signed (Month, Day, Year)

Janvar

19,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 15, 2012 10:03 AM Evdokia Gioulakis-Totos Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Montgomery Rockville Lutheran Home If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛚 F Days Hours Jul 19, 081-42-8255 Russia 1915 Director 96 Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗌 Yes 2 і No N. Potomac MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 20878 USA 14720 Maine Cove Terrace 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White If Yes. Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with n and Mental Hygien is marked other th Healthcare 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ourania Zafiropoulou permit. Page 1 and 2 should be Department of Health and Menl Important: If item 27 is marke any injury or other traumatic to Gregory Polychronidis other traumatic 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Gioulakis-Stockman 14720 Maine Cove Terrace N. Potomac, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 01/18/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen ring Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between COMPLICATION OF RIGHT Onset and Death Immediate Cause (Final Hip Promician/ tracture disease or condition resulting in death) Medical Examiner respiratory Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury urosepsis -transit and that initiated events Due to (or as a donsequence of) resulting in death) Last ing physician a e as the burial-t Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of deat 5 Other (specify) signed by the a 1 Yes 2 g Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Cerebrovascular accident 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s autopsy performed? Yes 2,4 No has 1 Yes 2 No certificate To the Hospital or accession 24 hours after death.

To the Funeral Director. After this certifies 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 🗌 No 1 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at wheel chair (Month, Day, Year) ☐ Matural Accident 5 Pending Fell out work 2 DNo 09/2012 1 Tes Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 P FLOOR DINNER 28f. Location (Street and Number or Rural Route Number, City or Town, State) 470 i VIER DE ROCKVIIIE, MD, 2085 determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie DOD64624 chally 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 743 SUMMER WALK DR. GATTHERSBURG, MI) SHARMA SANDEEP 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2 Physician/ 6:28 2012 P M Irma Martin Garvey Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore Genesis Cromwell Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Country) 0475371924 Director 87 213-20-3781 Baltimore, MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "not----" any injury or other than "not----" 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No HARFORD Bel Air MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral US 21014 300 Sunflower Dr., Apt. 344 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married à If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ Anna Martin Bowman Christian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Garvey/Son <u>4632 Walther Ave., Balto., MD</u> 21214 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 01/19/2012 Baltimore, MD Garrison Forest 4 Doyation 5 Other (Specify) 22. Name and Address of FacilitySchimunek Funeral Home e of Funeral Service Licenses 21. Signa MacPhail Rd., Bel Air, MD 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? To the Hospital or Attending Physician; The law requires that the death Month Day 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? After this certificate 1 Yes 2 No To Be 25. Was case referred to medical eral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 2- No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) icate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 No Accident Suicide Investigation 6 Could not be Certifi 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pertifying Nurse Practioner: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only or 29b. Signa**k**u e and title of certifie License number 29d. Date signe (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

address of person who complete

00

0

ause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year MARY B. GOLDSMITH 40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GOOD SOMMOKITOON BATTIMONE
If Under 1 Year | If Under 24 Hrs HOSPITA Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🛛 F Months Hours 9/6/1942 Director 214-38-7542 69 PANAMA Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 8623 OAK ROAD 21234 USA Funeral than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: þ 3 Widowed 4 Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY PLUMBING CO. 11TH GRADE marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If iten 27 Is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ FRANK ALTMEYER AVIS UNAVAILABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK GOLDSMITH/HUSBAND 8623 OAK ROAD PARKVILLE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 1/18/2012 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee M01139 non 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PAILUNE ACULTE RESTINATORY CARDIOLITHIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MISSELVE KYTICHTION OF LIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): INFARCTON Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed FIGHEL ONSTRUCTION MURPHUM CARRONIMUY and physician a s the burial-t Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) been signed by the should be detached Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ENVISTAGE MENTE PLSETTE 1 □ Yes 2 □ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Phlum remont as e 2 s page 2 performe this certificate 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No .1☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death | Director: / | d in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled ir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier 29c. License number 30. Name and ordress of pason who completed cause of death (Item 23a) (Type, Print) 17. TOSON 1661 LOCH MANUN BOILEV MUD, BATTMONE 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Fasure All Copies Are Legible.
Amend 7626 per DVR G923 1/20/12 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 9:05 A M 10, 2012 Harry Lee Hubble Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner White Hall Baltimore 1824 White Hall Road 8. Date of Birth (Month, Day, Yea Aug. 24, 9. Birthplace (State or Foreign Country) VA If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** Year) Days Hours Min. Months 94 Director 217-36-4960 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show ral", or items 23a or 28a-f shov Exercitor coust be notified at 1 ☐ Yes 🏖 ☐ No Director MD Baltimore White Hall the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 1822 White Hall Road 21161 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itel any injury or other traumatic event, the Medical Examples. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture 12 Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aaron Lee Hubble Kathern Mae White ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenneth Wirtz/Friend 1824 White Hall Rd. White Hall, MD 21161 20b. Place of Disposition (Name of Verried Remote Verried) 20c. Location - City or Town, State Date 20a. Method of Disposition 16, Jan. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 2012 White Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Methodist Cem. 22. Name and Address of Facility JJ Hartenstein Mortuary, Inc. 21. Signature of Funeral Service Licenses 24 N. Second St. New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner MS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cond quence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use con ute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>6</u> 2 d o 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only) friend's ^{6X}Other (Specify) residence Hospital: Other: 4 Nursing Home 5 Residence 2 Z No Medical Certification: To 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner eath 1 etural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determin 4 Homicide 29a. Certifier 1 Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) YOUKRD MONK 31. Date filed (Month, Day, Year) Registra's Signature State JAN Registrar

*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Fin nonth Physician/ Hudson 3,2012 304M Medical 4c. County of Death Eacility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner Burnle Baltimore Washington cHen If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number (In yrs. last birthday) 8. Date of Birth . Age **Funeral** 1 M 2 D F Months Days Hours Month, Day, Ye Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside Çity Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director Baltimore 1 Yes 2 No Maryland 10e Street and Numb 10f. Zip Code 10g. Citizen of What Country Ь than "natural", or items 23a o Funeral Hammor 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubay, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha aborer Be 18. Mother's Name (First, Middle, Maiden Surname) Hilda Mitchell 17, Father's Name (First, Middle, Last) ည John Hudson permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Acom Circle #301 Towson. Ma 19a. Informant's Name/Relationship (Type, Print) danahter sta 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other of 1 Burial 2 Deremation 3 Removal from State Cremator 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Vancal C-()) Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) anding physician a Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Control of the contro in the past 12 months?
1 Yes 2 No for Month Pregnant at time of death ed by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has certificate ☐ Yes Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer work? 1 Yes 2 No injury 1° Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature a d title of certi 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DWNSH-BOA 32. Registrar's Signatur

State

Registrar

JAN 20

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month January 19, Year 2012 5:21 AM Physician/ Teresa Louise Harrington Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕞 F Davs Hours Min. Junth, 03 Year 1950 216-54-0565 West Virginia Director Usual Residence of Decedent f show ems 23a or 28a-f shorements and second secon 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 N. Janney Street 21224 United States or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner Armed Forces?
1 ☐ Yes 2 ➡ No Black, White, etc. 1 Never Married 2 Married ۾ Maryland 21215-0036 1 ☐ Yes 2 ➡No Specify. "natural", White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Ike Lovejoy Carlita Hudson and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Daniel Harrington / Husband 107 N. Janney Street Baltimore, MD 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jate Jan 19 Page 1 1 🔲 Burial 2 🔀 Cremation 3 🔲 Removal from State cemetery, crematory or other place) Beltsville, Maryland Chesapeake Crematory 2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ movic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of, Exami burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 n Month Year Pregnant at time of death signed by the a d be detached f 1 Yes 2 9 🗌 Unknown Part II. Other significant conditions contributing to teath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 2 No 3 Probably Unknown Hyperteusion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\begin{align*}\) Other (Specify) \(\begin{align*}\) 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 🔾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated place. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) of certifier 29b. Signature and ti 29d. Date signed (Month, Day, Year, 5821500a mpleted cause of death (Item 23a) (Type, Print) Suite 4105, Balthream, MD 21204

State Registrar

DHMH 17 Rev 7/2009

6701

JAN 2 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ **HESS** 2012 10:15A^M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min **Director** 214-64-3393 1 🛛 M 2 🗆 F 57 07/02/1954 MD Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City. Town or Location notified at Director 1 Yes 2 X No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Completed by Funeral 3009 SUSANNE COURT 21117 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 1 Never Married 2 X Married 1 Yes 2 X No Hess |V| MC Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SECURITY AUDIO/VISUAL BUSINESS OWNER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **HESS** MAX **EDNA** SNYDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 RACHEL HESS / WIFE 3009 SUSANNE COURT, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW 01/19/2012 REISTERSTOWN, MD Signature of uneral Service bicense 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MN Medical Due to (or as a cons squence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b autopsy performed? Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DCA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cuntura Sman 00051347 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N-CharlesSt Baltimore MD 21204 ynthia Soriano 31. Date filed (Month, Day, Year)
JAN 2 0 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year JOHNSON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAMARITAN HOSPITAL BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
06-21-195 Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 60 Yrs. 214-62-671 **Director** Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County should re filed within 72 hours after death with the Maryland 10c. City, Town or Location by Funeral Director 10d. Inside City Limits MD BALTIMORE 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a RAVEN BLVD-APT40S 21239 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: BLACK Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should re filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is manued other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) VEOLA TRANSPORTATION USTOMER SERVICE REP Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JONES LILLIE JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BIVO. APT 40-BALTO, MO. 21239 DRENZO 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
ARBUTUS CEMETERY 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 1/25/12 Donation 5 Other (Specify) BALTIMORE, MD . Sig ure of an ervice Licensee AUGHN GREENE FUNERALSONS OAD. BALTIMORE, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Physician/ Myoca Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death 👊 not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes 25. Was case referred to medica 26. Place examiner? 2 🗌 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month John Michael Keane 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Manor Care Towson Nursing Center Baltimore County Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours 126-28-4554 75 Director July 07, 1936 1 👫 2 🗆 F Brooklyn, N. Y. Usual Residence of Decedent 28a-f show 10b County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Towson 1 Yes 2X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 509 E.Joppa Road 21286 United States 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. Peacetime 1 ☐ Yes 2 No Specify: White 3 Divorced 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. 12 04 Accounting Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F John Keane Mae Neville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shat Department of Health an Important: If item 27 is Mrs.Anne L.Anderson (Sister) 36 Norwick Circle Timonium, Maryland 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place).

Evans Funeral Chapel and Chemician Services, Inc. 20a. Method of Disposition Location - City or Town, State (Harford County) Date 1 Burial 2 Cremation 3 Removal from State Thursday any injury or 4 Donation 5 Other (Specify) Jan. 19, 2012 Forest Hill, Maryland 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. CFSP 22 Name and Address of Facility vess Funeral and Cremation Center, P.A.

22. Name and Address of Facility vess Funeral and Cremation Center, P.A.

2325 York Road Timonium, Maryland 21093-2215 23a. P. 11 Eng. the diseasy, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ euko Cytosi disease or condition resulting in death) Medical Due to (or as a consequence of Examiner erebra Cular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury YPer burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) ding physician Physician/Medical Box 68760 the as Se 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ō in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign be Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law page 2 autopsy performed death? 2 X No 1 Yes 2 🔀 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🔀 Natural 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide Investigation Could not be þ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined filled in I City or Town, State) Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 140054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Way, Lutherville, MD 21093 Sadi,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Roger **Physician** Kozazenko anuovy /Medical 4d. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 0.3/11/1951 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**□M 2□F 218-58-7505 60 France Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. It filem 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 XNo Director MD Baltimore Edgemere notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code must be 7214 Bay Front Road 21219 France Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2X No Black, White, etc. White 1 Yes 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 21 No þ 3 Widowed 4 X Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Factory Worker Steel Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophie Loska Ignacy Kozaczenko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1722 SW Angelo Street Port St Lucie FL34953 Jeanette James Sister Department of Healt Important: If item 2: any injury or other i 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/18/12 Atlantic Crem Glen Burnie MD 4 Donation 5 Other (Specify) 21. Signature of Foneral Service License 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Course vascul disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed ician and burial-trans Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 4-Unknown 1 Tyes 2 No 3 Probably Completed Be မ Certification:

Box 68760. P.O. Division of Vital Records, or Attending Physician: within 24 hours To the Funeral

				24a. Was an autopsy performed?	24b. Were autopsy morings available prior to completion of cause of death? 1 Yes 2 No				
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred					
3 Suicide 6 Could not be determined	Zoe, Flace of Injury - At Home, failth, Street, factory, office								
	vsician: To the best of my know niner: On the basis of examination				and manner as stated. place, and due to the cause(s)				

29b. Signature and title of ce

29d. Date signed (Month, Day, Year) BH 8258229

30. Name and address son who completed cause of death (Item 23a) (Type, Print) eamil

4940 Eastern Avenue, Baltimore, MD, 21224

State Registrar

Medical

31. Date filed (Month, Day, Year)

moun

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 11.32 1ANYARY 2012 2 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE RANDALSTUWN HOSDITA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral -4266 Months Days MARCH 1 ☐ M 2 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Nedical Exprinter must be notified at 10d. Inside City Limits 10b County 10c. City, Town or Location MARYLAND 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 0 ဥ 05 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Point Road BARA YUNGALK, MARYLAND 2422 0 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition JANUARY 1 ☐ Burial 2 Cremation 3 ☐ Removal from State BALTIMON, MARYLAND CRENTON FIC. 20 2012 BATIMON, MARYLAND-22. Name and Address of Facility W. DABBOWSKI, ChOTNACK, FUNERAL HOMES P.A. 1005 DONA JAIL AND BATT. MORE HARY LAND 21244 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such a scardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DISEA Immediate Cause (Final HEART **Physician** OSCL EROTIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). or Attending Physician; The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a I be detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred **Division** 1 Matural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: A 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 Homicide Hospital Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certification 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARSHALL ANKLIN SQUAREDR

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 12 Year Walker 23 17 PM **Physician** 2012 2annon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center Birthplace (State or Foreign Country) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F 82 213-62-8852 Sept 14, 1929 Director Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State "natural", or Items 23a or 28a-f show dical Examiner must be notified at 10b. County 1X Yes 2 ☐ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21224 USA 346 S. Drew St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 🗓 No Specify: g 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than Bethleem Steel janitor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Helen Tomczak is marked Casimir Karzak ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) it. Pages 1 and -- ant of Health and
-- m 27 is Concetta M. Karzak - wife 346 S. Drew St; Baltimore, MD 21224 permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🗓 Other (Specify) in State 21. Signature of Funeral Service Licensee Romald S. Was 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non covdio pulmonory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) death certificate be executed attending physician and d for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year in the past 12 months? Pregnant at time of death 2 🗌 No 9 Unknown the The law requires that the 9 Unknown ρ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 Yes of Vital 25. Was case referred to medical examiner? or Attending Physician: funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 1 Yes မ 27. Manufer of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division hours after death. Ineral Director: After 5 Pending investigation Injury 1 Yes 2 🗌 No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) hiper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 ☐ Medical Exa and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

21215-0036

Maryland

Baltimore,

Box 68760,

P.O.

Records,

troffmann

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signa

Dewnia

tomusing

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 01718/2<u>01</u>2 3:10 P M Constantine David Kryzanowsky Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Ingleside At King Farm If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 X M 2 🗆 F 03/09/192 WA 90 Director 346-16-1813 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show is unatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Directo MD 1 🗌 Yes 2 🙀 No Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other the..." 20850 United States 701 King Farm Blvd. Apt# 143 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give þ 1 ☐ Yes 2X No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1942-70 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Military Russian Linguist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Irma Etsell Wenzel Kryzanowsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Bural Route Number, City or Town, State, Zip Code) Janet R. Hoveland (Wife) 701 King Farm Blvd. Rockville MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State Beltsville, MD Chesapeake Crematory 4 Donation 5 Other (Specify) 01/21/2012 22. Name and Address of Facility 933 Gist Ave 21. Signature of Funeral Service Licenses M0038Z 2091 Rapp Funeral & Cremation Ser. Silver Spring MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MONTHS Immediate Cause (Final Physician ACUTE KIDNEY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown Day Month Pregnant at time of death g Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 🗆 No Yes 2 X N 1 Tes certificate 25. Was case referred to medical examiner?
1 ☐ Yes ②XXNo 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After work?
1 \(\subseteq \text{Yes} \) 5 Pending injury within 24 hours after death.

To the Funeral Director: A 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 19, 2012 D34590

25+1

Registrar

DHMH 17 Rev 7/2009

acked

20814

ROY FRIED M.D., 7758 WISCONSIN AVE. #211, BETHESDA, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 2 0 2012

		-	For State Registrar	State of Ma	ryland		artment <i>tificate</i>			and M		giene Reg. No.	201	2 01	187
			Decedent's Name (First, Middle, Last)					2. Date of Deat			ath		3. Time of		
	Physicia Medic		BORIS			KLOTS				JANUA	RY 16	Year 2012	21:5	8 P M	
	Examin	er	4a. Facility Name (if not institution, give street and number) SINAL HOSPITAL OF BALTIMORE			ORE	4b. City, 1		more		ITY	4c.	4c. County of Death N/A		
	Funeral		5. Social Security Number 6. Sex		(In yrs. las	st birthday)	If Under Months				8. Date of Birt		a p:	rthplace (State or	Foreign
	Director		216-92-5315 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	EW 2 0 1		73 Yrs.					05/317	1938		UKRAI	NE
	yland f show ed at	tor	10a. State 10b. County			, Town or Lo					_			10d. Inside Cit	
	h the Marylan 3a or 28a-f sh be notified	Direc	MD BALTIMO	RE	OW	INGS 1	MILLS 10f. Zip	Code				10a Citi	izen of What C		2 🔼 No
	ith with th ms 23a o must be	Funeral Director	5228 STONE SHOP (CIRCLE			211					US		odini y :	
	death v items ner mu		11. Marital Otatoo	12. Was Decedent Ev Armed Forces?	er in U.S.	. 13.	Was Decede	ent of His fy Cuba	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi		
336	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Completed by	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	10		1 🗆 Yes 2	∑ No	Specify:				Specify:	ITE	
2-0	2 hours aft "natural", edical Exa	plete	15. Decedent's Edu (Specify only highest grad	cation	- 1		dent's Usual			t of workin	na	16b. Ki	nd of Business		
21215-0036	thin sne. tha	Som	Elementary/Seconday (0-12)	College (1-4 or 5+	-)	life. D	O NOT use RIGERA	retired)					REERT	GERATION	V.
d 2	filed within all Hygiene.	Be	17. Father's Name (First, Middle, Last)			TCDI .	KIOLIU				(First, Middle,	Maiden S		obidii ioi	<u>. </u>
ylar	Menta Menta narked	욘	SHIKA			KLOTS	MAN		KHA	NA			MOR	DAYEVA	
Maryland	2 shouth and the and the strain t		19a. Informant's Name/Relationship (Type ALLA DOVBYSH / W)			l .	•	•			Route Numbe			ip Code) MD 211	1 7
	ye 1 and 2 should be filed wir t of Health and Mental Hygie If item 27 is marked other or other traumatic event, ∰		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Nam	e of	-		Date OW		ocation - City o		L /
Baltimore,	Page ment c ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	1	ALTIMO	-	•		1/18	/2012	R	EISTER	STOWN, M	ID
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service I cense			22					LEVINS			, INC. , MD 212	208
			23a. Part 1. Epter the disease, or compleshock, or heart failure. List only one	cations that caused to cause on each line.	the death	. Do not ent				-				Approximate Interval Bety	е
B	Pnysician/		Immediate Cause (Final disease or condition	INTRA			ULA	R H	IEM	OR	RHAGI	5		Onset and D	Death
Т	Medical Examiner		resulting in death)	Due to (or as a			D-11)				,			, WE	EK
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequ	ence of).								7 00 0	
	cuted and transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	RESP Due to (or as a	IRA	TOR	Y DE	FPR	ESS	100	J			3 HC	ours
0	ate be executed ohysician and the burial-transit	dical E	resulting in death) Last	Due to (or as a	conseque	51106 01/3									
68760	certificate be nding physicia use as the bu	Medi	IF FEMALE:	1.											
Box 6	eath certificat attending ph I for use as th	ian/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o	f pregnar E Fetal	death 3	Ectopic p	regnanc	у				23d. Date of d Month		/ear
	he death or y the atter sched for u	Completed by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 9 Unknown	time of a	eatn 5 L	Uther (spe	есту)							
P.O.	law requires that the de has been signed by the le 2 should be detached	by P	Part II. Other significant conditions cor					ause giv	en in Part	4.				o the cause of d	
rds,	equire: een sig	eted	CHRONIC K	IDNEX	DI	SEAS	E							Probably 4 🗆 I	
Division of Vital Records,	e law r e has b ge 2 sh	Jdwo										psy ormed?	prior to death?	utopsy findings a completion of c	ause of
al R	ding Physician; The la h. After this certificate ha funeral director, page	Be Co	25. Was case referred to medical					26. Pla	ace of Dea	th (Check	1 \(\sime\) Yes	2 1 No	1 L Y	es 2 1 No	
Z.	Physician; r this certific ral director,	잍	1 L Yes 2 No	ospital:					4 ⊔ N	ursing Ho	me 5 🗆 Resid	dence 6	☐ Other (Spe	cify)	
n of	ding P h. After t funera	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	Year)	28b. Time o injury	M 28	3c. Injury work 1	rat ? Yes 2 ⊑		28d. Describe I	now injury	y occurred		
isio	Attending er death. ector: After by the fune	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At hor	ne, farm, str				_	28f. Location (\$ City or Tov			ural Route Numb	oer,
Ö	Hospital or 24 hours afte Funeral Dire ted filled in I									_ 1					
	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completed filled in by the	Medical	29a. Certifier 1 Certifying Physic (Check only one) 3 Certifying Nurse	er: On the basis of exa	amination	and/or inves	tigation, in n	ny opinio	n, death o	ccurred at	the time, date a	and place,	, and due to the	cause(s) and ma	nner stated.
	To the within 7 To the comple	~	29b. Signature and title of certifier				29c.	License	number			29d. Dat	te signed (Mor	th, Day, Year)	-10
				MBBS	-11- 41	00-1/7		5 ~	018	012		JAY	VUAR	1 16,2	012
_	B√		100	OTRA,	SIr	VAI	HOSP	ITA	د ز	F	BALT	im	orte		
	Sta Registra	e ar	31. Date filed (Month, Day, 72012	32. Registrar	's ggnatu	parks	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #200&30 Per FH Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month Physician/ Sidney Keemer 1732 2012 Medical 100 4a. Facility Name (if not institution, give sifeet and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard County General Howard Columbia Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours Min. M 2 □ F 219-26-6028 Director 71 May 29,1940 Maryland Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland by Funeral Director notified 1 Yes 2 No MD Anne Arundel Pasadena 10f. Zip Code ō 10e. Street and Numbe 10g. Citizen of What Country? ms 23a or must be r 8195 Old Mill Road 21122 U.S.A. ural", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced er than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8th Grade Owner Keemer Sanitation Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Parker Allen Evelyn Keemer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8195 Old Mill Rd., Pasadene, MD 21122 Shirley V. Keemer (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 1/20/2012 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 1/23/201-2Haven Cem. Glen Burnie, MD 21. Signature of Funeral Service Licens Name and Address of Facility Joseph H. Brown, Jr. Funeral Home, PA 2140 N. Fulton Ave, Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Myocardial disease or condition Medical resulting in death) Due to ur as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No bacterenia 24a Was an page 2 s autopsy performed this certificate Yes 2 No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director; After 5 Pending 1 Natural work?
1 \sum Yes 2 \sum No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0066 515 M. D Jan 17 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard County General Columbia, MD aWa 31. Date filed (Month, Day, Year) 32: Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY Patricia Ripley List 1³7,20⁶12 10:55AM Medical Facility Name (if not institution, give street and number)
SAINT JOSEPH MEDICAL CENTER Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. . Social Security Number Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Months 234-38-2253 **Director** 1 □ M 💥 🗆 F Apr.10,1929 82 West Virginia Usual Residence of Deceden 28a-f show at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director injury or other traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2 🕅 No Parkville MD Baltimore 10e. Street and Number 10f. Zip Code ō 10g, Citizen of What Country? Funeral 23a 21234 2927 Edgewood Avenue USA items? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. rmed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give white "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) May Company Retail Sales should be filed with and Mental Hygien is marked other th 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Ripley Catherine Laffey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s.
Department of Health a
Important: If item 27 is
any injury or cet. 2927 Edgewood Avenue-Parkville, Maryland 21234 Charles List-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Dulaney Valley
Memorial Cardens 1 Durial 2 Cremation 3 Removal from State Jan.21,2012 Timonium, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YEAR Immediate Cause (Final MULTIFACTORIAL RESPIRATORY FAILURE (CHRONIC) Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of 1 YEAR Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine YEAR ABDOMINAL AORTIC ANEURYSM that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical 1 YEAR CHRONIC OBSTRUCTIVE LUNG DISEASE Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ō in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Year 9 Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATRIAL FIBRILLATION, PERIPHERAL VASCULAR 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed DISEASE, CACHEXIA, END STAGE LUNG DISEASE, LUNG 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy MASS perform death? 2. No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1X Natural 5 Pending iniury ours after death. eral Director; Aft filled in by the fur 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, 24 hours Medical 29a. Certifier 1 🏅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d, Date signed (Month, Dav. Year) anopid Kamul 18 2012 D0065641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAMAL BANGORIA, M.D. 7601 TOWSON, MD 21204 OSLER DRIVE

Registrar

31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month \mathbf{P}^M January Theresa Lambert Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Genesis Eldercare -Heritage Center Dundalk 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2**X** F 1077674926 MaryTand Director 215-20-7312 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No Dundalk Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 1 Funeral U.S.A. 21222 111 Briarwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Yes 2 🔀 No Specify: 3 Divorced 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Mill Steel Worker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eleanor Niner John Pape 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 111 Briarwood Road, Dundalk, Maryland 21222 Philip Lambert, Jr. (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Holly Hill Mem. Gard: 01/23/2012 Baltimore, Maryland 4 Demation 5 Other (Specify) anatale of Eugeral Servi 22. Name and Address of Secility Ski Funeral Home, P.A. 26 1407 Old Eastern Avenue, Essex, Maryland 21221 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 3a. Part 1. Enter the disease, or shock, or heart failure. List only o Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last MALNUTRITION Physician/Medical attending p IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No Pregnant at time of death ed by the a detached f 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERIAL 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K No e Hospital or Attending Physician: The 1.24 hours after death.

e Funeral Director: After this certificate h 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28c. Injury at 28a. Date of injury 28d. Describe how injury occurred 27. Manner of Death Certificate: (Month, Day, Year) 1 X Natural 5 - Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

State Registrar

Medical

29a. Certifier

(Check

Maryland 21215-0036

Baltimore,

Box 68760

P.O. E

Division of Vital Records,

use of death (Item 23a) (Type, Print)

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 14,2012 Physician/ Month Lorraine L. Letke 7:20P Medical anuary 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Harford BelAir 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days 1 - M 2 X F Hours Min. 212-28-9381 80Yrs Director June 26, 1931 Maryland Usual Residence of Decedent 28a-f shov 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No Md. Harford BelAir ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n 1112 Spalding Drive 21014 USA Unit D 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ ö 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: "natural" Completed 3 X Widowed 4 Divorced er than "natura the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Bethlehem Steel Admin. Asst. 1 and 2 should be filed with Health and Mental Hyginitem 27 is marked other other traumatic event, to Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Christopher Ruley Lillian Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR 1939 Colleen Drive North Huntingdon, Pa. 15642 Deborah Mumpower fitem 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date 1 XBurial 2 \square Cremation 3 \square Removal from State Bel Air Memorial 1-18.2012 Bel Air, Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home, of BelAir nte Cu 610 W. MacPhail Road BelAir, Md. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Stantolocalas bacteren.a disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Acrimon Mull man Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Exam almonory Polisin Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the ard be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes should should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner's Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Outlifying Nurse Prestigner: To this basis of my knowledge due to continue date and place, and due to the date and place, and due to the date and place. To the I only sind 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1000725 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 110 S. Paca 2nd Flour MD 21201 32. Registrar ignat State Registrar

DHMH 17 Rev 7/2009

3

Lette, Lorraine

100001569H

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 2309 Physician FRANCES JANUARY 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 X 68 212 42 1166 Maryland Nov.10,1943 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2x No Baltimore Maryland Essex Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ō USA 21221 1745 Earhart Rd. Items 23a death \ Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Ite 1 Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Yes. Give δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Physical Education School Teacher Harford Co. Schools 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Hyg Important: If item 27 Is marked othe any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) Arthur Rullman Francis Lawson Mary Doris Chaillou 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1745 Earhart Rd. Baltimore, Maryland 21221 John Michael Lawson (Son) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cemetery 1/23/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licens Bruzdzinski Funeral Home P.A. An W. Burkowske 1407 Old Eastern Avenue Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE HYPOXIC RESPIRATORY FAILURE TWO DAYS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SIX YEARS DIASTOLIC CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner NINE YEARS I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and burial-transit CORONARY Due to (or as a consequence of) resulting in death) Last Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death in the past 12 months?

1 Yes 2 No 1 Live birth 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PLEURAL 2 No 3 Probably 4 Unknown MALNUTRITION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an WOLLND /ULCER NON-HEALING autopsy performe FIBRILLATION 2 X No 2 🗌 No ATRIAL Division of Vital 26. Place of Death | Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No ၉ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide

To the Hospital or within 24 hours a To the Funeral D completely

Registrar

Medical

29a. Certifier

one)

(check only

29b. Signature and title of certifier

MUHAMMAD

31. Date filed (Month, Day, Year) -

30. Name and address of

DHMH 17 Rev 1/2001 11595

ATHAR, MD

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0072498

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

MD

sorr who completed cause of death (Item 23a) (Type, Print)

WAQA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:02 ewis Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death dnion Baltimor MOHI a 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. -8562 Months Hours **Director** 39 19 show 10d. Inside City Limits 10c. City, Town or Location the Maryland at Director notified 28a-f N/A Baltimore 1 X Yes 2 No MD 10f. Zip Code 21218 10e. Street and Number 10g. Citizen of What Country? 5 items 23a or ner must be r Completed by Funeral 1902 Homewood Ave. Page 1 and 2 should be filed within 72 hours after death with USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian, and Mental Hygiene. 'is marked other than "natural", or iter raumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/ADisabled N/A 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked or other traumatic even ဂ Yvonne Nicholas Jeff Lewis, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1902 Homewood Ave. Baltimore, MD 21218 19a. Informant's Name/Relationship (Type, Print) Jeff Lewis, Sr. -Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or ot 1 D Burial 2 Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemet. 1/30/2012 Baltimore, MD 21. Signature of Funeral/Service Licensee 22. Name and Address of Facility March F/H East 1101 E. for home MD 21202 North Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury for use as the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 WNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d, Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident 24 hours after death Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AT2438946D16 mo

Registrar

DHMH 17 Rev 06-2011

State

201E. University PKWY Batt. MD 21218

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chamian Date filed (Month, Day, Year)

ttambalam

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17,2012 Month Physician/ 0715 January Dolores Mary Mayer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 2,1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Maryland Director 218-03-2452 1 □ M 2 💢 F 91 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If tiem 27 is anarked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baldwin Md. Balto. 1 🗌 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21013 USA 12926 Fork Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give White 1 ☐ Yes 2 XNo Specify. Specify. 3 🕅 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Kramer William H. Zbrowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR Jasontown Road Westminster, Md. Suzanne Hyson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial 1-21-2012 Fallston, Md. Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Nottingham, Md. 21236 9705 Belair Road Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final ration Phylician disease or condition resulting in death) Medical Due to ar as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 4 Pregnant
9 Unknown 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown this certificate has been sireral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy n*ecolo*5965 performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🔲 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending I hin 24 hours after death. the Funeral Director: After 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) າ 24 hours a ie Funeral [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
☐ Contrying Numer Practitioner: To the best of my knowledge, death occurred at the time, date and place, and on to the cause(s) and manner stated
☐ Contrying Numer Practitioner: To the best of my knowledge, death occurred at the time, date and place, and on to the cause(s) and manner stated (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 DUO65827 ne and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 17 State of Mary 2004, 000 art 10 26 Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mina Moises Mena 2012 January 3:35 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Febonth 3 Pay, El Salvador Director 613-10-6007 76 T935 Yrs. Usual Residence of Decedent 10a. State Director 10c. City, Town or Location 10d. Inside City Limits or 28a-f sk notified a MD Prince George's Laurel 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be r Funeral 9010 Briarcroft Lane Apt 104 20708 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. ò ò 1 Never Married 2 X Married Maryland 21215-0036 1X Yes 2□No Specify: Salvadorian If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Worker Construction 6 of Health and Mental Hygi item 27 is marked other other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Gabino Mina Francisco Mina Juana Mena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 3712 Lamberton Square Rd. #1615 Silver Spring, MD of Health a Sonia Mina/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ott Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 01/20/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Subdural Hematoma Medical Due to (or as a consequence of) **Examiner** Fall Sequentially list conditions, Due to for as a consequence of if any, leading to immedicause. Enter Underlying Exami attending physician and for use as the burial-transit Metastatic Lung Cancer Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 9 Unknown signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? Yes 2 X No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes 2 □ No ၉ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending P n 24 hours after death. e Funeral Director; After t Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Mechanical fall ground level 1 Natural
2 XAccident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 XNo 01/05/12 0630 Investigation completed filled in by the hit head 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec*ify)* **atuxent River Health & Rehab.** 28f. Location (Street and Number or Rural Route Number, MD determined 14200 Laurel Park Dr., Laurel Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the P within 2 To the P 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year D37142 January 18, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman, M.D. 1355 Piccard Drive Rockville, MD 20855 31. Date filed (Month, Day, Year) -State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. David William Mollet State of Maryland / Department of Health and Mental Hygiene 2012 01196 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death 3. Time of Death Physician/ January 8, 2012 **Medical Examiner** David William Mollet 1058 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 159 8th Avenue SE Glen Burnie Anne Arundel 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director 352-50-3596 Months Days Hours 07/13/1955 1 M 2 F 56 Country) IL Yrs Usual Residence of Decedent 404 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits MD Anne Arundel Glen Burnie items 23a or 28a-f show 1 Yes 2 No with the Maryland rector 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 514 N Crain Hwy 21061 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1X Yes è If Yes, Give Year or Dates: 3 Widowed 4 X Divorced 1 Yes 2X No specify: Specify: White ፩ 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within. Department of Health and Mental Hygiene. Important: If iten 27 is marked other that injury or other traumatic event, the Medical 12yrs Electronic Mechanic Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Mollet Barbara Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Harris Daughter 7317 Brown St. Sykesville MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) 1/14/11 Atlantic Crem Glen Burnie MD 4 Donation 5 Other Specify. 22. Name and Address of Facility Simplicity Crem & Fun Ser 21. Signature of Eugeral Service Licenses ThomasAllenPA 7090 Ridge Rd Hanover MD lome 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atherosclerotic Cardiovascular Disease complicated **Physician** Approximate Interval Between Onset and Medical Death Immediate Cause (Final disease a. by Hypothermia kaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a nonsequence of): ner cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 1 and transit The law requires that the death certificate be executed Physician/Medical UNPENDED attending physician or use as the burial -AMENDED 23a, 27, 28a-f, per me, g923 1-25-12 sm Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed has been s 24a, Was an 24b. Were autopsy findings available prior to completion of cause of performed?

✓ Yes 2 No death? certificate 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital å Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene this uneral dire ER/Outpatient 3 DOA 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month. Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Bospital or Attendin within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Natural subject exposed to cold environment 5 Pending 1 Yes 2 X No fd 1-8-12 fd10:15am 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) (rear of) 159 8th Ave S.E. Glen Burnie, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined (Specify) Fd:In tent in wooded area Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 9, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ling Li, MD 31. Date filed (Month, Day, Year)
JAN 2 0 2012 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month / 03 7 2012 Year 1:00p M Silvia Meneses Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Keswick Multicare 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthpiac Country) 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Min. (Month, Day, Year) 0 / 2 3 / 1 9 4 0 1 - M 2 XF 71 unk **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director NY New York 1X Yes 2 ☐ No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 644 West 173rd Street 10032 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. o permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked any injury or after. Completed by 1 Never Married 2 XMarried 1 Yes 2**X** No 1X Yes 2 ☐ No Specify: Hispanic Cuban Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8ys Teacher Aid Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Violeta Moebios Juan Rodriguez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 644 West 173rd Street New York New York Husband Prospero Meneses 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Atlantic Crem 01/07/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cecebrovasoles disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underwing Examine Due to (or as a consequence or). Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of). resulting in death) Last physician a sthe burial-t Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death g 🗌 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an as 2 autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Sulcide
4 Homicide Accident Investigation Director: / Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours at To the Funeral D completed filled in Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 DO059056 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 west yorn St B014 Registrar's Signa State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Miernicki 20 A Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard Genera County clumbia Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 03/13/1934 PA **Director** 77 1 XM 2 ☐ F unk Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Ellicott City MD Howard 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a or ner must be n Funeral 9382 Paulskirk Drive 21042 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status er than "natural", or ite Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Goodyear 4yrs District Manager of Health and Mental Hygi item 27 is marked othe other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Isabelle Wowack Anthony Miernicki 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Rose Marie D. Miernicki 9382 Paulskirk Drive Ellicott City MD21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 1/19/12 Atlantic Crem Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv Signature of Funeral Service Licensee + home ThomasAllenPA 7090 Ridge RD Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Acuk disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner neulnzon Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use : yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death 9 Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 🗹 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation 24 hours after deatl Funeral Director: 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

Francis

31. Date filed (Month, Day, Year)

JAN 2 0 2012

Lane

(2 Jum)16

< colar

5755

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1022 Month O Physician/ MOSON Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** Baltimore Mercy Medical Center If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) UNK Days Min. Hours Director 212-44-7099 66 1 XM 2 □ F 26 March or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Baltimore 1 Yes 2 □ No MD unk unk 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 72 hours after death with 11. Marital Status unk 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 black 1 Yes 2 X No Specify: If Yes, Give Specify: 3 - Widowed 4 - Divorced Completed Year or Dates. ntal Hygiene. ced other than "natura event, the Medical E 16a. Decedent's Usual Occupation UNK
(Give kind of work done during most of working 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) h and Mental Hygien unk unk Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mercy Medical Center 345 St. Paul P1; Baltimore, MD 21202 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, re of Funeral Skrvice License Remald S 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Metastatic Onset and Death Immediate Cause (Final Physician cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and -trai Due to (or as a consequence of) physician arts the burial-t resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by (preumonia cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🐼 No Other: မ 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending e Funeral Director: Aftu e Funeral Director: Aftu pletely filled in by the fur 1 ☐ Yes 2 ☐ No Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) within To the 29b. Signature and title of certifier Medical Doctor NPI 1104051945

Registrar DHMH 17 Rev 06-2011

State

345 St. Paul Place Baltimore, MD 21202

Name and address of person who completed cause of death (Item 23a) (Type, Print),

Registrar's Signat

Smelter

31. Date filed (Month, Day, Year)

01/07/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. State Registral 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) 135 Month Physician/ VAEH Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner /A TIMOR OF MARYLAND MEDICAL CENTE UNIVERSITY 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number 4.14 6. Sex Country) Months Hours **Funeral** 10/20/ 1 🗆 M 2 💢 F 2011 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10h County death with the Maryland must be notified at Director 1 Yes 2 No Baltimore N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe ö USA 21218 23a Funeral 2201 Cecil Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene.
Important: If item 27 is marked *** er than "natural", or iter the Medical Examiner 1 Never Married 2 Married Specify: Black 2 Yes 2 No Specify If Yes, Give Year or Dates 3 🗌 Widowed 4 🗆 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) N/A N/A $A \setminus A$ 18. Mother's Name (First, Middle, Maiden Surname) Be NIA 17. Father's Name (First, Middle, Last) Monique Moore ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2201 Cecil Ave. Baltimore, MD 21218 Monique Moore-Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition
1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Zion Cemetery 1/20/2012 Lansdown, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H East 1101 E. 21. Signature of Funeral rvice Licenses North Ave. Baltimore, MD 21202 1. M.C. Bran 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTIORGAN disease or condition resulting in death) Physician/ Due to (or as a consequence of) Medical Examiner PREMATUR Se wentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Vear Month in the past 12 months? Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ this certificate has been signed ral director, page 2 should be de ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical completely filled in by the funeral director, Be Other: 4 \(\Boxed \) Nursing Home 5 \(\Boxed \) Residence 6 \(\Boxed \) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 1 Yes 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 27. Manner of Death within 24 hours after death. To the Funeral Director: After Natural 5 Pending Investigation 2 Accident
3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospital Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29c. License numbe of certifie

Registrar

State

PYAIL

31. Date filed (Month, Day, Ye

REENS

BACTIMORE MO 21201

SUTTE GSIID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAMER

295

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 tem 5 per fh 2923 1-26-12 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Edith Medley Physician/ 1/9/2012 Day 9:05 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimor Towson Gilchrist Hospice 5. Social Security 74579 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Hours 5/2/1936 219-30-6537 75 Director Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f shot raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 X Yes 2 No MD 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code Completed by Funeral 21214 4829 Gilray Dr. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give Specify: 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Good Samaritan Elementary/Seconday (0-12) B.S. Degree Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Elanore Solmon Theodore Logan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodney Medley Jr. -- Grandsoh 4829 Gilray Dr. Baltimore, MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) St. 4 X Donation 5 ☐ Other (Specify) Anatomy Board: 1/18/2012 Baltimore, MD 22. Name and Address of Facility March F/H East 21. Signature of Funeral Service Licensee North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ year disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): physician at the burial-t resulting in death) Last Completed by Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death 9 Unknown a I Inknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an was a... autopsy performed? this certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) To the negative within 24 hours after death.

To the Funeral Director: After the funeral on by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide Hospital or Attending 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | Medical Examiner: On the basis or examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) 6701 N Charles

Registrar

State

31. Date filed (Month

Records, P.O. Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 18, 2012 8:06 P M Mary Carmella Mister Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Bel Air Upper Chesapeake Medical Center M00009660 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Director 212-40-5165 1 🗆 M 2 🔀 Jan. 28, 1929 82 Marvland Usual Residence of Deced or items 23a or 28a-f show 10d. Inside City Limits ntal Hygiene.

ed other than "natural", or items 23a or 28a-f showert, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 No Harford Maryland | Edgewood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3041 Ebbtide Drive 21040 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 **X**No þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home is marked other Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ပ Anna Louise Mancuso William Harvey Chappell injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 3041 Ebbtide Drive, Edgewood, Maryland 21040 Frederick Wells / Companion 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn 1-21-2012 Bel Air, Maryland 21. Signat Je of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line RONAR DISEASE Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence on use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 M No Pregnant at time of death Other (specify) signed by the at d be detached for Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate I Yes 2 L funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural iniury 5 \square Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Phy ician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 5 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 chesapeake Drive Bel Air, mD 21014 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

2-00059		Please Type or Print in Black Indelibi			ible.
Keith Jarret Nigh	nten	otato of marylana, popularion	it of Health and Menta e o <i>f Death</i>	l Hygiene	2012 0120
BL		Registrar 1. Decedent's Name (First, Middle,Last)	e or Dealir	Reg. 2. Date of Death	. No. 3. Time of Death
Physicia Medical Exami		Keith Jarret Nightengale			Day Year Doop has
		4a. Facility Name (if not institution, give street and number) Western Maryland Regional Medical Center	4b. City, Town, or Location of E Cumberland	Death	4c. County of Death Allegany
Funeral Director		5. Social Security Number 2 1 5 - 0 4 - 0 3 4 9 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 3 2	y) If Under 1 Year If Under 2 Months Days Hours Yrs.	4Hrs. B. Date of Birth Min. 11/19/	(MM/DD/YYYY) 9. Birthplace (State or 1 9 7 9 Foreign NC Country)
yland -f show any once,	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I MD Allegany Cu 10e. Street and Number	Location mberland	1100	10d. Inside City Limits 1 Yes 2 No Citizen of What Country?
th the Maryland 23a nr 28a-f sho notified at once.	Director	8 Pennsylvania Ave	21502		USA
r death wi or items	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Pales:	3. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Portion 1 Yes 2 X No specify:		14. Race - American Indian, Black, White, etc. White Specify:
215-0036 be filed within 72 hours afte nital Hygiene. rked nither than "natural", ent, the Medical Examiner			cedent's Usual Occupation (Give kining most of working life. DO NOT us		6b. Kind of Business/Industry
D36 thin 72 ne.	Completed	10th		N/A	N/A
5-0 led wi Hygier nther		17. Father's Name (First, Middle, Last)		lame (First, Middle, Ma	
O 8 2 2 3	Be	John Robert Nightingale 19a. Informant's Name/Relationship (Type, Print) 19b. N	lailing Address (Street and Numbe	verly Ann	
22 sho	٩	Beverly Ann Schiver Mother 8			
2 4 5 7	Ш		isposition (Name of cemetery, or other place)	Date	20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of He impartant: If ite		4 Donation 5 Other Specify: Atlan			Glen Burnie MD
Baltimo permit. Page Department Impurtant: injury or ot					y Crem & Fun Serv
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not en	TNOMASALLENPA nter the mode of dying, such as card	iac or respiratory arres	ge Rd Hanover MD t, shock, or heart Approximate Interval Between Onset and
Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of):			Death
		Sequentially list conditions, b			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		27-1	
executed an and al - transit	Exar	events resulting in death) Last Due to (or as a consequence of): d.			
0 7 7	dical	▼ UNPENDED	e,g924 2-15-12 s	m .	
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 1 Unknown 2 Unknown 1 U	Fetal death 3 Ectopic pr	regnancy	23d. Date of delivery Month Day Year
P.O. Bc that the des ned by the s detached fo	Phys	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	. 23e. Did tob	acco use contribute to the cause of death?
P.C. res that signed be deta	d by			1Yes	2 No 3 Probably 4 V Unknown
Division of Vital Records, P.O. Box 68760, the Hospital in Attending Physician: The law requires that the death certificate being the Funeral Director: After this certificate has been signed by the attending physician phetely filled in by the funeral director, page 2 should be detached for use as the buring.	Completed			24a. Was an autopsy perform	prior to completion of cause of death?
ital Rediction: The scertificate rector, page	Be	25. Was case referred to medical examiner? Hospital: 1 location 2 FP/Output	26.Place of Death (Clastient 3 DOA Other		
O Of Vi ding Physi After this funeral dir	၉	1 Yes 2 No I I I I I Pauleit 2 Y E1000496 27. Manner of Death 28a. Date of Injury 28b. Tim	atient 3 DOA Oule 4 N e of Injury 28c. Injury at Work?	ursing Home 5 R	esidence 6 Other:
OD C cending sath. or: Af the fun	tion	1 Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 N		
Divisi nital nr Att urs after de rral Direct	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm (Specify)	, street, factory, office building, etc.	28f. Location (Str or Town, Sta	reet and Number or Rural Route Number, City tte)
Divisior To the Hospital nr Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or inveand manner stated.			
	ž	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) January 3, 2012
		39. Name and address of person who completed cause of death (Item 23a)	/ Daltimara Otania B. W	ND 04000	
		Laron Locke MD. Assistant Medical Examiner 900 W 31. Date filed (Month, Day, Year) 32. Registrar's Signature		re, MD 21223	
St Regis	tate trar	31. Date filed (Month, Day, Year) 2012	Mar		

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #3, per phy, g923 1-20-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Deatl Physician/ 2374 XO 1 Medical 4a. Facility Name (if not institution, give street and number) 4c.County of Death Baltimore **Examiner** 4b. City, Town, or Location of Death 4410 Wrenwood Avenue Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **72** 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month Day Year) 214-68-4826 1939 Maryland **Director** 1 🗆 M 2 😽 Usual Residence of Deceden 28a-f show items 23a or 28a-f shoner must be notified at with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Windsor Mill 1 Tes 2-No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7203 Bogley Road unit 203 21244 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Black, White, etc. ò 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. þ 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify 'natural", Completed 3 Widowed 4 Divorced Specify. Black 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Sales Retail event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ည Henry Wilson pe Gloria Sewell permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paige Pullen /Daughter 4410 Wrenwood Avenue Baltimore, MD 21212 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date an 1 20c. Location - City or Town, State 1 🗌 Burial 2 🖼 Cremation 3 🗀 Removal from State Chesapeake Crematory 2012 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee, 22. Na Generatia on Family Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No be detached Unknown the 9 Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed should been Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform hours after death. Ineral Director: After this certificate Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury filled in by the Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d Date signed (Month, Day, Year) on who completed cause of death (Item 23a) 69

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

Year

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Medical 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death Catonsville Baltimore Charlestown Care Center If Under **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2X F Months Director 219-18-1895 Maryland 87 Usual Residence of Decedent 28a-f show 10a. State 10b. County 72 hours after death with the Maryland Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits MD Baltimore Catonsville 1 Yes 2 No 0 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral items 23a 21228 USA 709 Maiden Choice Lane, 212S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give 0 Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Specify Year or Dates or other traumatic event, the Medical Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) rould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank A. O'Connell Katherine L. Lanahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .0 Health 3663 Rusty Leaf Court, Waldorf, Maryland 20602 Michael F. O'Connell / Nephew permit. Page 1 and Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, XBurial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 1/20/2012 Baltimore, Maryland New Cathedral Ceme. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicin Due to (or as a consequence of) disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Pregnant at time of death 5 Other (specify) Day Year the 9 Unknown g Unknown P.0. ed by t signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page performed' 1 Yes 2 No Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medica director, Be 26. Place of Death (Check only one) Hospital 2 No 1 Tes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Accident Investigation the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier D44377

State Registrar Choice

210

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stephen C. Owens 3:14 2013 JANUARY Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner N/A MARYLAND GENERAL HOSPITAL BALTIMORE Social Security Number If Under 1 Year If Under 2 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours 7/31/1960 213-64-1726 Director 1 X M 2 □ F Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No N/A Baltimore MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 2601 Madison Ave. Apt. 407 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🕅 No Specify. Specify: Black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Disabled G.E.D. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Justine Gaskins Wardell Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2501 Violet Ave. Apt.1313 N Balto., MD 19a. Informant's Name/Relationship (Type, Print) Justine Owens-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2💢 Cremation 3 🗀 Removal from State Greenmount Cemet. 1/23/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H East 1101 E. 21. Signature of Funeral Service Licensee North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTIPLE Provincian/ disease or condition Medical resulting in death) as a consequence of) Examiner DAG ULOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami HEPATITIS To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 🗆 No 9 Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 2 🗌 No 3 🗎 Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 🗌 Yes ပ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28a. Date of injury 28d. Describe how injury occurred Certificate: within 24 hours after death,

To the Funeral Director: After of the completely filled in by the funer 1 Natural (Month, Day, Year) 5 Pending Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1/14/2012 1-14-12 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND GENERAL HOSPITAL C/0 CHEEMA , M.D. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donovan Virginia January 12:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2136 Davidsonville Rd Crofton Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Director 1 □ M 2**XX**F Yrs. Jan 8, 1925 87 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant If if item 27.5 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or orther traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No MD Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 21060 USA 304 New Jersey Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 XX Married Yes If Yes, Give Year or Dates 1 ☐ Yes 2 kmNo Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DMV State of MD 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frederick H. Fahlke Nancy E. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. O'Donovan Husband 304 New Jersey Ave., Glen Burnie, MD 21060 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Jan 25, 2012 Glen Burnie, MD Glen Haven Cemetery 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Fink Funeral Home, P.A. K Gregory Fink 101148 426 Crain Hwy S., Glen Burnie, MD 21061 Part 1. Enter the disea shock, or heart failure. ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardivascular Atheroscientic disease or condition resulting in death) Medical Due to (or as a consequence of) Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying burial-trar Be Completed by Physician/Medical as the Date of delivery Vionth Day ontribute to the cause of death? 3 Probably 4 Unknown

Examiner or Attending Physician: The law requires that the death certificate be executed after death. and physician Division of Vital Records, P.O. Box 68760 page 2 should has

Baltimore, Maryland 21215-0036

Cause (Disease or injury that initiated events	C. *					
resulting in death) Last	Due to (or as a conseq	uence of):				
_	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗌 Ectopi	c pregnancy specify)		23d. Date of de Month	elivery Day Year
Part II. Other significant conditions co	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.		_	o the cause of death? Probably 4 \square Unknow
				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s 2 No
25. Was case referred to medical examiner?			26. Place of Death (Che	eck only one)		
1 ☐ Yes 2 ☐ No	Hospital: 1 lnpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing I	Home 5 Residence	6 d Other (Spec	Ka Living Aci
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury M	28c. Injury at work? _1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		ory, office	28f. Location (Street a City or Town, Sta		ıral Route Number,
(Check 2 Medical Examin	ician: To the best of my know ner: On the basis of examinatio e Practitioner: To the best of	n and/or investigation,	n my opinion, death occurred	at the time, date and pla	ce, and due to the	cause(s) and manner sta

29d. Date signed (Month, Day, Year)

MD

1/19/12

2120

ASS SKA Living Acilil

DHMH 17 Rev 06-2011

State Registrar

Medical Certificate: To

nsky apahu Mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2135

29b. Signature and title of certifier

N.5 Kajapaksy M.D

the

To the Hospital within 24 hours a To the Funeral L Hospital

5min N

29c. License number

5703

00057463

Rabinore

Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death Baltimore, Maryland 21215-0036 Physician Medical Examiner -transit and burialphysician the burial Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl signed by the a d be detached f certificate has page After this

Physician/

Medical

Director

Funeral

þ

Completed

Be

ဂ္

Examiner

Physician/Medical

Examiner

Funeral

Director

show

ns 23a or 28a-f s must be notified

23a

ted by	- Stabetes		1 Yes 2 No 3 Probably 4 Unknown						
Completed					24a. Was an autopsy performed? 1 ☐ Yes 2 🌠 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No			
Be	25. Was case referred to medical examiner?			26. Place of Death (Chee	ck only one)				
To E	1 ☐ Yes 2 No	lospital: 1	ER/Outpatient 3	DOA Other: 4 Nursing H	lome 5 Residence 6	Other (Specify)			
rtificate:	27. Manner of D th 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred			
S	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factor)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Medical	29a. Certifier (Check only only only only only only only only								
	29b. Signature and title of certifier		2	9c. License number	29d. Date signed (Month, Day, Year)				
	They	42 x	n 18,2012						
	30. Naryo and address of person who co			amthell]	Black B	alto, nd 2123			
e ir	31. Date filed (Month, Day, Year) JAN 2 0 2012	2. Registrar's Signa	bark	/					
09		,	,,						

State Registrar

within 24 hours a

To the Funeral D

12-00542 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Barry Leo Pelley 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 19, 2012 1415 hrs **Medical Examiner** Barry Leo 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 1110 Elkridge Landing Road Room # 614 Linthicum Anne Arundel If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Canada country) Days Hours Director Sept27,1959 116-825-167 52 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No it. Pages I and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show y or other traumatic event, it is Medical Examiner must be notified at once. Kinburn Ontario Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2220 Styles Side Road KOA 2HO Canada 13, Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No White 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year Specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Director of Engineering Ciena Corp. 12th 4yrs 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Russell James Pelley Vivian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code KOA 2HO 19a, Informant's Name/Relationship (Type, Print) <u>Francina Maria Pelley/W</u>ife Styles Side Road Kinburn, Ontario Canada timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, (unkt) 20c. Location - City or Town, State Capital Mem. 1 Burial 2 Cremation 3 X Removal from State Gards Ontario,Canada 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Kaczorowski Funeral Home, PA $M0093\overline{3}$ Dundalk Avenue Baltimore, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset end failure. List only one cause on each line /Medical Death a. Head and Neck Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit cian/Medical g physician a: the burial - 1 UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, F FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the attending p for use as th 2 Fetal death Live birth 3 Ectopic pregnancy Year Month Day past 12 months? Pregnant at time of death 5 Other (Specify) a signed by the atte Physi 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed? 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Other Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 1 Yes funeral 28a. Date of Injury FOUND: 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject fell FOUND: 1 Natural 1 Yes 2 ✔ No death. 5 Pending within 24 hours after death To the Funeral Director: the Jan 19, 2012 1408 hrs 2 🗸 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 1110 Elkridge Landing Road Room # 614, Linthicum , M determined (Specify) Hotel/Motel 4 Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001 **OCME 2006**

State

OCME

29b. Signature and title of certifier

Melissa Brassell, MD

and manner stated

Assistant Medical Examiner

32. Registrar's Signatur

Diane l 30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

29c. License number

O.C.M.E

900 W. Baltimore Street, Baltimore, MD 21223

29d, Date signed (Month, Day Year)

January 20, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle) Last) 2. Date of Death 3. Time of Death Physician/ Month O/ 134 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F 900-30-6792 0473944 Country) MD Director 67 Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Anne Arundel Severna Park 1 □ Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 220 McKinsey Road 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Specify. White 1 Never Married 2 Married Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Financial Sales 4yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Paul Patterson Sr. Anne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lance J. Patterson Son 220 McKinsey Road Severna Park MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 1/14/12 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie MD Atlantic Crem Signature of Funeral Service Lice 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. STAGE Immediate Cause (Final Arrest and Prass Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of. Examin physician and s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b, Signature and title of certifier 29c. License number 2012 12 Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS MONYOI NEFENSE

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend #10e&f Per ANA BD C023 1/20/2012 III State of Maryland / Department of Health and Mental Hygiene amend #4aPer PHY 	 PER ANA BD G924 2/17/2012 JH 2 0 | 2 Certificate of Death For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Day Year PASSLEY distance 1-00AM Medical Jani 4a. Fability Name (if not institution, give street and number)
Ellicott City Health& Rehab. 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Howard Ellicott City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | Aug 3, 1949 7. Age (In yrs. last birthday) Funeral Social Security Number 6 Sex 9. Birthplace (State or Foreign Country) Jamaica 220-37-7171 1 X M 2 A F Director Usual Residence of Decedent 23a or 28a-f show ortant, if item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Howard Columbia 10e. Street and Number 8843 Harthorne CT. 10f. Zip Code 10g. Citizen of What Country? Funeral 21043 21045 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: black If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation un 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Zadia Passley Vernon E. Passley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Passley - wife 8843 Hawthorne Ct; Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signature Funeral Serve, License 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ M 40 CARDÎA L Due to (or s a consequence of): INFARCTION disease or condition resulting in death) Medical Examiner YPERTENSION Sequentially list conditions, Due to (or as a consequence of, if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury anding physician and use as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Po Month Day 5 Other (specify) Year Pregnant at time of death signed by the a d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dependent Trabelles 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? Hemplegia 24a. Was an autopsy performed? Yes 2 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A М Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number . 30469 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) N-VELLANKI, 8850, COLUMBIA 100 PARKWAY, # 308; COLUMBIA, MD. 210 45. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 2 0 2012

Registrar

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Year Month 200P M 017 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City, Town, or Location of Death 4c. County of Death Nursing 12abeth altimor If Under 24 Hrs. 8. Date of Birth Mours Min. (Month, Day, July 4) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 1 □ M 2 🏻 F Director 87 Washington DC 577-26**-**4759 Usual Residence of Decedent 28a-f show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21201 524 N. Charles St; Apt 1410 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 Never Married 2 Married Black. White, etc. Completed by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: 3 Divorced Specify: white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) veterans affairs federal government permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Richard Victor Riggle Stella Nauwerck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Ritenour - niece 3005 Stranden Rd; Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board ture of Funeral Service Ronald 655 W. Baltimore St; Baltimore, MD 21201 23a. Part . Enter the diserve, or complications that cause shoot or heart failure. List only one cause on each line . Enter the diserve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) oronary a Medical **Examiner** Myoc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and -transit Exami Due to (or as a consequence of): burial-t resulting in death) Last attending physiciar for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death ed by the a 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 X No Other: ျင 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death completed filled in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred : After 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier anuary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mooth, Day, Year) 3320 ww and 2122 State Registrar

Box 68760

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 1012 RAINE AUNA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SILUER SPRING HOSPITA MONTGOMER CROSS 9. Birthplace (State or Foreign Country) UN If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months 037-14-3400 **Director** 1 M 2 VF 04,1930 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27; is marked other than "natural", or items 23a or 23a.c.t.amy injury or other trainmair. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No SILUER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral NEW HUMBHSIRE AUB 209 VZ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Yes Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give 3 🗌 Widowed 4 🗀 Divorced Completed WHITE Year or Dates. 16a. Decedent's Usual Occupation unk (Give kind of work done during most of life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 FOREST GLEN RD SPRING MD HOLY CROSS HOSPITAL SILVER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 N Other (Specify) in state Ronal Licens 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death SEPSIS Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner BNEMWONN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month the g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> The law requires KIDNRY FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen s HYPERTENSION 24a. Was an Were autopsy findings available prior to completion of cause of death? has page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only on Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 332 32 06, 2012 of person who completed cause of death (Item 23a) (Type, Print) GUP 9801 GEORGIA SILVER SPRING MD AUE

State

Registrar

JAN 20

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Junius Bernard Reed Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Baltimore **Examiner** Gilchrist Towson Social Security Numbe 6. Sex 1 **X**M 2 □ F If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days Hours Min. 5/2771945 219-42-5648 66 Director MD Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits 10c, City, Town or Location must be notified at Director 1 Yes 2 No N/A Baltimore MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? iral", or items 23a Examiner must be Funeral USA 2466 Brentwood Ave. 21218 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 ☐ Married 2 🗆 Yes 2 💢 No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black "natural" 3 Divorced 4 Divorced Completed Year or Dates 27 is marked other than "nature traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Elementary/Seconday (0-12) Various Jobs Laborer 12th Be 18. Mother's Name (First, Middle, Maiden Surname) Sarah Price 17. Father's Name (First, Middle, Last) nd Mental P ည Junius B. Reed, Jr. of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7813 Mallow Ct. Pasadena, MD 21122 Eric Scott-Son other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of himportant: If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Druid Ridge Cemt. 1/23/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H East 1101 E. 21. Signa ure of Funeral Service Licensee Ma North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death ≁πysician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 1 Yes 2 L a Unknown Hospital or Attending Physician: The law requires that the 24 hours after death. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellious Coronary anterio 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 2 🗆 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital 1 🗌 Yes Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 2012 8

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day,

6701

TOWSON MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAMES

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel 7423 Phelps Rd Hanover Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex ege (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours **Director** 212-26-1985 1 ☐ M 2 ₩ Jan 24, 1927 84 MD 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XXNo Anne Arundel Hanover o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a LISA 7423 Phelps Rd. 21076 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2XX No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 9 Completed by 1 Never Married 2 X X Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes XX No Specify: Specify. White "natural" 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Carrier/clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hilda Cora Virginia Millender Howard Patterson de Health ar. n 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7423 Phelps Rd., Hanover, MD 21076 Husband Charles Ruby 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ± 5 1 XXBurial 2 Cremation 3 Removal from State Important: If any injury or once, Jan 23, 2012 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet Cem Signature of Funeral Service 2 Name and Address of Facility Fink Funeral Home, P.A. K. eredoky 426 Crain Hwy S., Glen Burnie, MD 21061 M01148 Enter the r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Approximate Interval Betwee shock t only one cause on each line Immediate Cause (Final disease or condition resulting in death) On et and Peath EMENI Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 mont Pregnant at time of death Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 ☐No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 1 \square Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate i ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 WNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Watural injury work? 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) O 2017 38 Name and address of person of death (Item 23a) (Type, Print) DEFENSE HWY

Registrar
DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last)
Mario Jaime Rivero-Hernandez 2. Date of Death Physician/ January 16, 2012 3:25 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9812 Mahogany Dr. Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 446-32-1584 Months Director 81 1 🕅 M 2 🗆 F 11/9/1930 Bolivia 28a-f show 10d. Inside City Limits 10b. Count 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Directo MD Montgomery Gaithersburg 1 Yes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9812 Mahogany Drive 20878 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No 1956-Black, White, etc. 0 þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ₺ Yes 2 □ No Specify: Bolivian White If Yes, Give "natural", 1959 Completed 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Civil Engineer Fed. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ Horacio Rivero-Eguez Cristina Alicia Hernández-Santivanez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13849 Mustang Hill Ln. North Potomac, MD 20878 Sophia L. Schmidt, daughter item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Uniformed Svcs. Univ. 1/18/2012 Bethesda, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Service Dicensee M00382 Stishittoller 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ ALZHEIMER"S DEMENTIA disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ **EMPHY SEMA** 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Hospital or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: ပ္ 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury XX Natural 5 Pending 1 Yes s after death. 2 No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29b. Signature and title of certifier

Box 68760

P.O.

Records,

Division of Vital

Registrar DHMH 17 Rev 06-2011

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

KADIE E. LEACH M.D.,

JAN 2 0 2012

31. Date filed (Month, Day, Year)

29c. License number

9500 ANNAPOLIS RD. A-1, LANHAM, MD

D27521

29d. Date signed (Month, Day, Year)

20706

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cynthia Ruff:n 12:09 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland of Baltimore Medical Ctu N/A If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 215-80-1852 Hours (Month, Day, Year) **Director** 1 □ M 2 □**X** 08/04/1969 |Maryland 42 28a-f show 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1 Ves 2 No MD N/A Baltimore 10e, Street and Number 10g. Citizen of What Country? 23a Funeral Cynthia A. Ruffin 21216 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married marked other than "natural", or Š 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 🗌 Widowed 4 🗌 Divorced Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) should be filed within and Mental Hygiene. Housewife N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Michael L. Thomas Sr. Dorothy Gaves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health item 27 Michael Ruffin(Husband) 1122 Braddish Ave., Baltimore, MD 21216 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Surial 2 Cremation 3 Removal from State Mt.Zion Cem. 01/21/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Joseph h. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death INTRACEREBRAL HEMORRHAGE) Immediate Cause (Final ICH Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Year Pregnant at time of death
Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗷 No Yes 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No မှ 1 Yes 1 A Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) N.D. Pulmonary and 1-13-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Baltimore Ayal Street Romem MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elizabeth Kidd Riordan 6:30 A January 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 212-38-2690 1 □ M 2 🕱 F 83 Aug. 24, 1928 Maryland Usual Residence of Decede 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2515 Kidd Road 21047 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry tal Hygiene. •al Hygiene. •ar than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) School Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Joseph Kidd Sr. Elizabeth (nmn) Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Riordan III/Son 2546 Kidd Road, Fallston, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 1-13-12 Towson, Maryland of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 54/515 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner neumannie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ğ Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 ☐ No 1000/629/6A **Division of Vital** Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 HNO 1 Yes ဂ္ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending ours after death.

leral Director: Af

filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Configure Prantitioner: It is no ested by including, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) husentali 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 500 upper chesipeate Apuna 31. Date f d (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 2012 8:55 AM Riley Flossie 15 Jan. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** N/A Manor Care Health Services Baltimore Social Security Number Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday **Funeral** Min Months Davs Hours 03/25/ Director 1930 214-26-6783 81 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 🗆 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe items 23a Funeral 301 McMechen Street, 21217 Apt.#517 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? "natural", or iter ledical Examiner r Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) event, the 6th Grade Child Care Provider Private Homes Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellis Braxton Carrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Smith (niece) 4016 Jacinth Way, Baltimore, MD 21236 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Woodlawn Cem. 01/23/2012 Baltimore, MD 22. Name and Address of Facility
Joseph H. Brown
2140 N. Fulton 21. Signature of Funeral Service kicensee Ave.; Funeral Home, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ breat disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed ionprun Cause (Disease or imjury the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death signed by the a g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? page 2 certificate 1 Yes 2 No 2 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ie. Other: 2 **1**00 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after dec.
ral Director: After ...
by the funeral dir After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗀 No Accident Investigation Suicide Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of D31464 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

30

HASHMIMD

32. Registrar's Sig

21 N. EUTAW ST SuitE 208 BALTIMORE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last). 2. Date of Death 3. Time of Death Physician/ 11:10AM anuary 201 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N altimer Year If Under 24 Hrs. 8. Date of Birth April 6, 190 **Funeral** 7. Age (In yrs. last birthday) If Unde 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 Min. Months Hours Country) **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2121 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify: Blac 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) ife. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) amille Be 17. Father's Name (First, Middle, Las 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code HIMRE Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, MI athmore 4 ☐ Donation 5 ☐ Other (Specify) ton 21. Signa of Funeral Service 22. Name and Address of Facility MO 23a. Part 1. Enter the disease, or complications that or used the death. Do not unter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes No be detached 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform 1 Yes 2 No Yes the Hospital or Attending Physician: Inin 24 hours after death.

the Funeral Director: After this certifics mpleted filled in by the funeral director, t Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? Division Accident Suicide 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29c. License number 16 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death **Physician** Month Year SCHULL 2012 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death RELLING PEKINA (JENESB Baltimore Parkville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours Year) Months 1 □ M 2**X** F Yrs Director 92 120-10-2633 October 08,1919 Queens, New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director Parkville 1 ☐ Yes 2XXNo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21234 United States 2908 Knoll Acres Drive items 23a filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 □Yes 2 No þ Specify: 3√Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of than Elementary/Secondary (0-12) College (1-4or 5+) Defense Administrative Assistant 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any fullury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maria Spaletta Giovanni Valenti 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, John Schumm (Son) 2908 Knoll Acres Drive Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulancy Valley Memorial
Carcers 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State January 18, 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 2012 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 21. Signature of Funeral Service Licensee ettell 23a. Part 1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. Like only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPERCAPNIC DESTIRATORY **Physician** /Medical Due to (or es a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transi and Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant et time of death 3 🔲 Ectopic pregnancy in the past 12 months? 5 Other (specify) 2 346 1 ☐ Yes 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☒ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2/2/No Other: 1 ☐ Yes 1 Inpatient this Certification: To 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation To the Hospital or Autenamy within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 🗌 No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O.

Baltimore, Maryland 21215-0036

State Registrar

MITSAN 821 N-GTAW 31. Date filed (Month, Day, Year)

JAN 2 0 2012 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

4 Homicide

(Check only one)

29b. Signature and title of cartifier

29a. Certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

STK.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

57E

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

12-00446 Sarah Sheats Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 0122

		1- For State Registrar	Certificate of	f Death		,,,	Reg. No.		
Physici edical Exami		1. Decedent's Name (First, Middle,Last) Sarah Katherine Sheats				2. Date of De Month January	Day 15, 2012	′өаг	3. Time of Death 2202 hrs
)		4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital		4b. City, Town, Baltimore	or Location of De			y of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In y. 216-78-0042 1 M 21 F 4	rs. last birthday) 6 Yrs			Min	irth(MM/DD/YY 0, 1965	Foreign	
nd thow any	r		City, Town or Locat	tion					10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 3500 Woodring Avenue		10f. Zip Code 21234			10g. Citizen of V USA	What Coun	try?
er death with th , or items 23a r must be noti	Funeral	11. Marital Status 1 Never Married 2 Married 1 Yes 2 N N N N N N N N N N N N N N N N N N	lf Y		an, Mexican, Pue	(Specify Yes or N erto Rican, etc.)	W	nite, etc.	an Indian, Black,
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland not of Health and Mental Hygiene. Anti of Health and Mental Hygiene and "natural", or items 23a or 28a-fake anti. If item 27 is marked other than "natural", or items 23a or 28a-fake or other tranmatic event, the Medical Examiner must be notified at once	leted by	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+)	d) 16a. Deceder during m	nt's Usual Occup nost of working li	eation (Give kind fe. DO NOT use		16b. Kind of		
5-003 led within Hygiene. I other tha	Completed	12 17. Father's Name (First, Middle, Last)	Medica	al Assis	18.Mother's Na	ame (First, Middle,	Healt		
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. In 27 is marked other than marke creek, the Medical	To Be	A. James Sheats 19a. Informant's Name/Relationship (Type, Print) Gilmour Kuhns/mother			eet end Number	r Kuhns or Rural Route Nu ederick,			Zip Code)
ore, Miges 1 and 2 so of Health a tritem 27		20a. Method of Disposition	0b. Place of Dispos crematory or oth	sition (Name of c	emetery,	Date	20c. Locatio	n - City or T	
Baltimore, permit. Pages l ar Department of Hee Important: If ite injury or other tr		21. Signature of Funeral Service Licensee	inal Jour	lame and Addre	ss of Facility Cremat	ion Serv	ice P.). Bo	× 784
Physician \/Medical		23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line. Immediate Cause (Final disease a. Complications of Christophia)							Between Onset and
Examiner		or condition resulting in death) Due to (or as a consequence sequentially list conditions,		•					
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e de la companya de l						
760, icate be executed physician and the burial - transit	edical Ex	d. UNPENDED X AMENDED 23a,pt		28a-f no	r ma ag	24 2-16-	12 vt		
68760, vertificate be tding physicis	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of p	oregnancy 2 Fe	etal death 3	Ectopic pre		23d. Date Month	of delivery Da	ay Year
b. Box 687. The death certification of the attending of the attending of the death	Physici	1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but n	3 <u></u> 0	her (Specify)	oiven in Part I	23e. Did	tobacco use cor	ntribute to th	ne cause of death?
ls, P.O. quires that th en signed by ald be detach	至	Benzodiazepine use			3		es 2 🗸 No	3 Proba	ably 4 Unknown
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach.	Completed					auto perfo 1 ✔ Yes	psy ormed?		empletion of cause of
fital sician: is certif lirector,	o Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	✓ ER/Outpatient		Other Nu		Residence 6	Other:	
	-	1 ✓ Yes 2 No Impatient 2 27. Manner of Death 1 ✓ Natural 5 Pending Investigation 2 🗶 Accident Investigation	28b. Time of li	njury 28c. Inj	jury at Work? Yes 2 K No	28d. Describe	how injury occu	ırred	lcohol and
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) hou		et, factory, office	building, etc.	28f. Location	State) 291	1 Ham	il Route Number, City
To the Hos within 24 h To the Fun completely	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	-						
F \$ F 3	Ň	29b. Signature and title of certifier			nse number		January		th, Day, Year)
IV		30. Name and address of person who completed cause of death (I Jack Titus MD. Deputy Chief Medical Exami		Baltimore St	reet, Baltimo	ore, MD 21223	1		
St Regist		31. Date filed (Month, DayYear) 2012 3. Registrar's Sign	atte	w					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1/14/2012 Physician/ 8:00 P <u>Lillian Shamer</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore Charlestown Care Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs, 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Months Days 3/30/1913 219-28-6025 Maryland Director 98 Yrs. Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🂢 No MD Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funera 21228 USA 709 Maiden Choice Lane, RG220N Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify Completed 3 X Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working th and Mental Hygiene.
27 is marked other than "
traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Worker Mfq. 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Severn Katie Thompson permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic of 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21108 Marie Meyer / Daughter 8029 Horicon Point Drive, Millersville, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 1/19/2012 Glen Burnie, Maryland Donation 5 Other (Specify) Glen Haven Mem. Pk. in ure of Funeral Service Prensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ans. disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) certificate be executed burial-transi Cause (Disease or injury that initiated events resulting in death) Last physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy for 5 Other (specify) Month Day Year Pregnant at time of death signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò stanosis 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy performed certificate 1 🗌 Yes 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 2/ No မ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 5 Pending Natural 24 hours after death. Funeral Director: A 2 🗌 No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MDRegistrar's Signa Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 1DNOB 6:13 au Medical 4a. Facility Name (if not institution, give street **Examiner** 4c. County of Death Medica Baltinere If Under 24 Hrs. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F 217-40-7116 Month, Day, Year) 16/1930 81 Yrs. **Director** N.C Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland notified at 10d. Inside City Limits Director N/A 1 XYes 2 🗆 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ıral", or items 23a or Examiner must be r Funeral 501 E. Preston St. Apt. 324 21202 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black "natural", Completed 3 Widowed 4 Divorced Specify: the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med Elementary/Seconday (0-12) N/A Midtown Nursing 9th Nursing Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked cary injury or other traumatic evence. မ Lawrence Stephen Sarah Love 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Player-Daughter 1261 E. Belvedere Ave. Apt.B Balto.Md 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1/20/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cemt. 21. Signature of Fundral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Baltimore, MD 21202 Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atte should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 1 Yes 2 🗌 No Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes TNo Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No ☐ Accident Investigation Could not be hours after death Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier сотретер 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Baltimore, MD 21202 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 16a-b, per fh, g923 1-20-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:00AM 2012 hnie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner - Boston NIA Baltimore are uture Date of Birth Month Day. Birthplace (State or Foreign Country)
 C If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 X Months Days Hours Min. 243-84-4482 00 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No **Funeral Director** MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4715 Hazelwood Ave. 21206 Itama 23a USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11. Marital Status 1 and 2 should be filed within 72 hours after o Health and Mental Hygiene. 8m 27 is marked other than "natural", or Itai 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black by 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7th Factory Unknown N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Bell Louise Outlaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If Itam 27 is any injury or other trau once. 243 N. Luzerne Ave. Baltimore, MD 21224 Theodore Smith-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Carmel Cemt. 1/23/2012 Baltimore, MD ' 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility March F/H East 1101 E. 21. Signature of Funeral Service Licenses North Ave. Baltimore, MD 21202 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** who /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, the leading limit solat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of a Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown á 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; certificate 1 Yes 2 No 21 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Matural М 1 Tes 2 🗌 No death. 2 Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 T Homicide within 24 hours a To the Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 01226 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Snyder 2012 1:09 P Sarah Montgomery January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4413 Brittany Drive Ellicott City Howard Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Min. 216-22-8711
Usual Residence of Decedent **Director** 1 🗆 M 2 🔀 F 85 July 16,1926 SC show at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector r 28a-f s notified MD Howard Ellicott City 1 ☐ Yes 2X No ö 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 4413 Brittany Drive 21043 United States death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after Yes 2 TNo If Yes, Give Year or Dates 1 Yes 2 No Specify. 3[★] Widowed 4 □ Divorced "natural" Specify: Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working ntal Hygiene. ed other than " event, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Data Entry Operator USF & G Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မှ Granville Harrison Montgomery, Sr. Paula C. Marshall ge 1 and 2 should be nt of Health and Men 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ulrich Speck Snyder/son 2727 Continental Road Chevenne, Wyoming 82009 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If it any injury or o Crest Lawn Mem Gardens 1/24/2012 Marriottsville, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Signature of Funeral Service Licenses 4112 Old Columbia Pike Ellicott City, MD 21043 uanta Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final DIABETES MELLITUS Physician) disease or condition resulting in death) 4+ YEARS Medical Due to (or as a consequence of) Examiner + YEARS MPERTENSION Sequentially list conditions, Il any leading to humanate cause. Enter Understanding Physician/Medical Examiner Due to (or as a nonsequence of, Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 ☐ Yes 2 X No 1 🗌 Yes of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖄 Natural 5 Pending injury Division 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063501 TANUARY 18 2012

Registrar

State

RABINA

31. Date filed (Month, Day, Year)

JAN 2 0 2012

ムと

724 MAIDEN CHOICE LANE SUITE 201 CATONSVILLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M-1

32. Registrar's Signature

MALIK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2012 $a^{\,\scriptscriptstyle{M}}$ 3:35 Rebecca F. Sterling Januarv Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Care Howard Columbia 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral Director** 218-08-3271 29 1 🗆 M 2 🔀 F 09/18/1982 MD Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD Baltimore Catonsville 0 10e. Street and Numb 10g. Citizen of What Country? 23a Funeral 1316 Woodburn Drive 21228 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 No Black, White, etc. by ò 1 X Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: If Yes. Give Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 1Elementary/Secondary (0-12) Massage Therapist Self-employed Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ George B. Sterling Patricia A. Schiller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau 10346 Waverly Woods Drive Ellicott City, MD 21042 Patricia A. Laun - mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2X Cremation 3 Removal from State Ardent Crematory 01/19/2012 Hanover, MD Donation 5 D Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Signature 4112 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final COMPLICATIONS OF HEVATITIS C. Due to (or as a consequence of): Physician/ disease or condition resulting in death) DECADES Medical Examiner BLOOD TRANSFUSION DECADES Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) I E FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Month Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \times \)Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death Director; / d in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral L within 24 hou

To the Funer

completely fill Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Image: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D64395 JANUARY 19,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE COLUMBIA, MA 21044 DANIEUE DOBERMAN, MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			_	Plea	i se Type d AMEN State	r Pri	nt in E EM#1p	Black Ir Der PHY	delible	ink 1/2	Ensure 20/2012	All Copie	es Ar	e Legi	ble.	0.1	000
			For State Registrar		Otato	- OI W	aryland		tificate			_	Reg. N	C 0	12		228
	Physicia Medic		1. Decedent's Name	Ma	~ d KIG	ell	Melv	in Se	llers			2. Date of D Month	eath	Day	Year	3. Time of	
	Examin	er	4a. Facility Name (if n	,			otor				ocation of Dea	ath	4	c. County o			
	Funeral Director		5. Social Security Nur 216–16–61	mber	6. Sex 1 XM 2 □ I	7. Ag	e (In yrs. las	st birthday) Yrs.	Park If Under 1 Months D	Year I	If Under 24 Hi Hours Min				Country	ice (State or	Foreign
		L	Usual Residence of D	Decedent								104/04/	1924	<u> </u>		yland	
	laryland 3a-f sh ified a	Director	10a. State	10b. County	imore			Town or Loc							100	d. Inside Cit	
	a or 28 be not	al Dir	10e. Street and Numb		.Inore			gnsvil	10f. Zip Co	ode			10g. C	Ditizen of W	hat Countr		
	ath with	Funeral	7701 Br	adshaw	Road	and ant I	Transin II C	110.14	210		i- Origina (2		U.S.A	•		
980	is flied within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 X Never Marrie 3 □ Widowed 4		ied Armed	Forces?		li i	Yes, specify Yes 2	Cuban, I	Mexican, Pue	Specify Yes or No rto Rican, etc.))-		- Americar , White, etc	о.	
21215-0036	72 hou in "natu Medical	Completed		ify only highe	nt's Education st grade complete			(Give I	ent's Usual O kind of work d O NOT use ret	one duri	on ing most of w	orking	16b.	Kind of Bus	siness Indu	stry	
	y within ygiene. her tha ht, the h	Be Co	Elementary/Secor	2		(1-4 or 5	(h+)		hnicia	· '				АТ	& T		
Maryland		To B	17. Father's Name (Fi							18		ame (First, Middle	e, Maider	n Surname)			
lary	2 should be file th and Mental I 27 is marked c traumatic eve	73	19a. Informant's Nam			,]	19b. Mailin	g Address (St	reet and		: Clark Tural Route Numb	per, City o	or Town, Sta	ate, Zip Co	de)	
	and 2 Health em 2 ther t		Gerald (tt (ne	phew			Bradsh		Road -	Kingsvi				2108	7
Baltimore,	~ ~ ~ ~			Cremation	3 ☐ Removal fro	om State	ce	metery, cren	cemet	r place)	01/	Date 17/2012		Location - 0	•		n d
Balti	permit. Page Department Important: I any injury o		21. Signature of Fune	eral Service Li	icensee		Tur	22	Name and A	ddress o	of Facility E	. F. Las	ssahı	n Fune	eralH	ome,	P.A.
			23a. Part 1. Enter the	e disease, or	assaks complications tha	d caused	I the death.					- Kings		le, Ma	1 /	Approximate	
	hysician/	8 9	Immediate Cause (Fi disease or condition	ina1	nly one cause on	each line	wh	4	drus	vice.	- v2)	ruate	14	fan	اسا	nterval Betw Onset and D	eath
Sec.	Medical Examiner		resulting in death)		Due t	o (or as a	conseque	1.1	ma	a	, and	c	- (1			
00		niner	Sequentially list cond if any, leading to imm cause. Enter Underly	nediate ying	b. Due t	o (or as a	a const que			7	5						
98	executed an and irial-transif	Examine	Cause (Disease or iir that initiated events resulting in death) La		c. Due t	o (or as a	a conseque	ence of):									
		dical			L d		_										
Box 68760	to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Euneral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent print the past 12 mo 1 □ Yes 2 □	onths?		e Birth		death 3	Ectopic preg					23d. Date Mont	of delivery		ear
O. B	at the de t by the stachec		9 Unknown		9 Ur		ut not rooul	Iting in the	edaylı da — ——		in Doubl						
S, P.	urres than signed and be de	ed by	Part II. Other signific	mi	v ~~~	\	m p	e fu		e given	in Part I.					cause of de	
corc	aw requas beer	Completed		1		#F						24a. Wa:	s an			y findings a	
l Re	ician: The certificate herector, page		25. Was case referred	to medical	-							per 1 \(\text{Yes}	formed?		ath? Yes 2	□ No	
Vita	lysicia is certi directo	To Be	examiner?		Hospital:	Inpatie	ent 2 🗆 E	R/Outpatien		Other:	of Death (Ch	eck only one) - Home 5 □ Res	idence	6 □ Other	(Specify)		
n of	ding Pr h. After th funeral			5 Pending	g (Mo	te of injur onth, Day	y (Year) 2	8b. Time of injury	i	Injury at work?		28d. Describe				-	
Division of Vital Records, P.O.	or Atten	Certificate:	2 Accident 3 Suicide 4 Homicide	6 Could n	not be 28e. Plan	ce of Inju ding, etc	ry - At hom . (Specify)	ne, farm, stre	M et, factory, off		s 2 L No	28f. Location City or To			or Rural R	oute Numbe	er,
	o the hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2:	Medical (29a. Certifier 17 (Check 2	Certifying Medical E	Physician: To the caminer: On the b	best of e	my knowled	dge, death o	ccured at the	time, da	ate and place,	and due to the c	ause(s) a	ind manner	as stated.	e(s) and man	ner stated.
:	lo the within 2 To the comple		only one) 3 [29b. Signature and title	□ Certifying	Nurse Practione	r: To the I	best of my k	knowledge, d	eath occurred	at the tir	ne, date and p	lace, and due to t	he cause	(s) and mani ate signed (ner as state	ed	
	_x\		1 12	A	700		· \	W		1)	MM	2 (b)		طال	112		
	/D,		30. Name and address	Bu	mut	~	un	(Type, Pr	(8808	l	J.LR	ur (61	w))		Paul	erlle	hay
	Stat Registra	-	JAN 20	2012	Ceren 32.	Registra	r's Signatur	We &								l	دي

01/4/2012

5.20AM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 18^{Day} Physician/ 2012 2:32 P M Sharon Thomas Jan. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Maple Ridge Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, 1 M 2 K Director 500-38-1600 10.1934 Missour Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral ige 1 and 2 should be filed within 72 hours after death with nt of Health and Mental Hygiene.

t: If item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must b. 20853 USA 15908 Maple Ridge Court 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give 2X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 2 vrs Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Cloughley George C. Low 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6505 Garden Grove Way Laytonsville, MD 20882 Kim Jalette/daughter Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State Department of Important: If any injury or once, Final Journey Crematory 01/23/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Cancer Years disease or condition Medical resulting in death) Examiner Years Breast Cancer Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on -transit and that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician a should be detached for use as the burial-Physician/Medical or Attending Physician: The law requires that the death certificate be after death. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Alzheimer's Disease Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Hypertension 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? this certificate has page 2 perform Yes 2 No 1 Yes 2 x No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 **X**No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Assit. Liv. To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 'Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 戻 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 01/20/12 D32332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 9801 Georgia Ave. Suite 2-20 Silver Spring, MD 20902 Suresh K. Gupta State

DHMH 17 Rev 7/2009

Registrar

12-00484 Brian Tibbs .lr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

onan Tibbs, Jr	State of Maryland / Department of Certificate of Registrar	f Death	2012 0123 Reg. No.
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) BRIAN TIBBS, JR.	2. Date of De Month January	Day Year 1949 hrs
	4a. Facility Name (if not institution, give street and number) 516 Sheridan Avenue	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 217 - 31 - 7183 1 M 2 F 20 Yrs Usual Residence of Decedent	Months Days Hours Min.	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) M.D.
the Maryland or 28a-f show any diffed at once. Director	10a. State 10b. County 10c. City, Town or Loca BATT IN		10d. Inside City Limits 1
D 21215-0036 should be filed within 72 hours after death with and Mental Hygiene. 7 is marked other than "natural", or items 234 natic event, the Medical Examiner must be not To Be Completed by Funeral	1 Never Married 2 Married 1 Yes 2 No 1 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) BRIAN K. TIBBS, SR	as Decedent of Hispanic Origin? (Specify Yes or Nes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No specify: nt's Usual Occupation (Give kind of work done lost of working life. DO NOT use retired) DST 18.Mother's Name (First, Middle ANGELA Y. May an address (Street and Number or Rural Route No SHERIDAN AVE. BAZ	White, etc. Specify: BLACK 16b. Kind of Business/Industry TG I F , Maiden Surname) RAMSEUR
Baltimore, MD School Permit. Pages I and 2 sho Department of Health and Dischool Inspertant: If item 27 is injury or other traumati	20a. Method of Disposition 1	CEMETERY /23/12 Name and Address of Facility V.A. M.C.H.A.	BALTIMORE, MO
Examiner	IF FEMALE: 23c. If yes, outcome of pregnancy	er me,g925 3-15-12 sm	23d. Date of delivery Month Day Year
P.O. Box es that the death of gned by the atter of detached for u I by Physic	Pregnant at time of death	sity;Asthma 1 Ye 24a Was auto perfc	
Division of Vital Records, spital or Attending Physician: The law require hours after death. Intra Director: After this certificate has been signified in by the funeral director, page 2 should the Certification: To Be Completed.	25. Was case referred to medical examiner? 1 Yes 2 No 1 No 1 Natural 5 Pending 2 Accident 1 Natural 1 New Pending Investigation	26. Place of Death (Check only one) 3 DOA Other Mursing Home 5 Dijury 28c. Injury at Work? 28d. Describe	Residence 6 Other: Scene
	3 Suicide 6 Could not be determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	or Town,	se(s) and manner as stated.
To the H within 24 To the Pf To the Re complete	2 Medical Examiner: On the basis of examination and/or investigate and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a)	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 18, 2012
_	Ling Li, MD Assistant Medical Examiner 900 W. Baltimor 31. Date filed (Month, Day, Year) AV 2 0 2012 32. Registrar's, Signature	e Street, Baltimore, MD 21223	
Registrar DHMH 17 Rev 1/2001	ORIV Z U ZUIZ I JANUA J. J. ORIGINAI		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State of Ma	ryland / Depa <i>Cer</i>	artment of H tificate of D			ene 201	2 0 23
	Physicia		1. Decedent's Name (First, Middle, Last) Pauline Eleanor Tebo				2. Date of Death Month Jan	Day Ye	3. Time of Death
	Medic Examin	al .	4a. Facility Name (if not Institution, give street and number)		4b. City, Town, or	Location of Death	Jan	14, 2012 4c. County of E	
- Jane	}		1005 Bush Road			ngdon			rford
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 □ M 2 🗓 F	(In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent				10/23/	1938	MA
	nyland I-f shc ied at	ctor	10a. State 10b. County MD Harford	10c. City, Town or Lo	cation	Abingdo	nn		10d, Inside City Limits 1 ☐ Yes 2X No
	the Ma or 28s e notif	Dire	10e. Street and Number		10f. Zip Code	- IID I II GU		0g. Citizen of Wha	t Country?
	s 23a	Funeral Director	1005 Bush Road			21009		U.S.A	
	r death	by Fu	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Every Armed Forces? 1 Yes 2 X		Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
903	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at the Medical Examiner must be notified at	q pa	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🛛 No	Specify:		Specify: V	Vhite
15-(72 hou n "natu Aedica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d O NOT use retired)	tion uring most of worki	ing	16b. Kind of Busin	ess/Industry
212	led within 7. Hygiene. other than ent, the Me		Elementary/Secondary (0-12) College (1-4 or 5-12 yrs		Cler	k		Municipa	al Court
and	be filed ental Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last) Simon Leo Pottie			18. Mother's Nam		aiden Surnarne) Desrosi	ers
ary	should be and Ment		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a			-	
ž	and 2 sh Health a tem 27 is		James Pottie (brother)		Bush Roa	d Abingd			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State		natory or other place	e) [20c. Location - Cit Glen Buri	
altin.	permit. Pa Departmer Important any injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee	Atlanti	C 2. Name and Addres				
ă	Depar Impor any ir		mas swell						and 21236
de	Medical Examiner physician and physician and sthe burial-fransit	edical Examiner	Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of): White	Essir	nellit ma	Ly		Approximate Interval Betyleen Onset and Beath Authoral year Authoral yea
). Box 68760	requires that the death certificate been signed by the attending phy should be detached for use as the	Ž	1 Yes 2 To g Unknown	2 Fetal death 3 time of death 5	Ectopic pregnanc Other (specify)			23d. Date o	Day Year
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed by P	Part II. Other significant conditions contributing to death by	ut not resulting in the u	underlying cause giv	en in Part I.	1 Ye	es 2 No 3	re autopsy findings available to to completion of cause of the cause o
ital	ician: Sertifica ector,	Be	25. Was case referred medical examiner?		Othe	ace of Death (Chec			
of V	g Phys er this neral di	te: To	27. Manny of Death 28a. Date of injur		nt 3 □ DOA f 28c. Injury	4 □ Nursing Ho		ence 6 Other (Sow Injury occurred	Specify)
ion	tendin leath. or: Aft the fur	Certificate:	2 Accident Investigation			Yes 2 No			
ivis	I or At after c Direct d in by	Cert	4 Homicide determined 28e. Place of Injubuilding, etc	ry - At home, farm, str . (Specify)	reet, factory, office		28f. Location (St. City or Town		or Rural Route Number,
L	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check Check 2 Medical Examiner: On the best of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner:	my knowledge, death	occurred at the time	e, date and place, a	and due to the cau	use(s) and manner d place, and due to	as stated. the cause(s) and manner stated.
2)	Fo the Northin 2. Fo the Footbet	Me	29b. Signature and title of certifier	best of my knowledge	29c. License	he time, date and pl	ens, and due to th	e cause s) and men 9d. Date signed (A	ner as stated.
	F S F Ö		>myletters	MD	\mathcal{V}	4567	7	01/11	6/20/2
_	P		30. Name and address of person who completed cause of do	edith (Item 23a) (Type.	PrintPLU H	REER	P. Sui	TE IK	BEL ATR
-	Sta Registr		31. Date filed (Month, Day, Year) 32. Registr	's Signatur	0		6		MP 2/0/5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY Day 2, 2001 2 Physician/ 9:17A Robert Peter Turso Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death c. County of Death
BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 133-20-0347 Director 1 XM 2 🗆 F Pennsylvania 80 10-22-1931 Yrs Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Harford Jarrettsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1609 Dulaney Drive USA 21084 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian Armed Forces?

1 X Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. White 3 ☐Widowed 4 ☐ Divorced Completed Year or Dates. 1950-1952 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+ Railroad Engineer should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 other traumatic Helen Savaikis Joseph Turso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kimberly T. Baum DTR. 1609 Dulaney Drive Jarrettsville, Md. 21084 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 1-13-2012 Glen Burnie, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. 610 w. MacPhail Road BelAir,Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate cause on each line. RESPIRATORY FAILURE Onset and Death Immediate Cause (Final Ph. sici. n disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CARDIOGENIC SHOCK Sequentially list conditions, If any, leading to minimediat cause. Enter Underlying Cause (Disease or injury that initiated events VAVULAR HEART DISEASE Exami death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 g Unknown 2 No 9 I Inknown Hospital or Attending Physician: The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 Yes 2 □ No 3 □ Probably 4 □ Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Yes 2 No this certificate has 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No ၉ 1XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: Af ed in by the fu 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 1 Gertifying Nurse Prantitioner 1. the best of my knowledge, destinonoured at the time, date and place, and due to the cause(s) and marrier as states 29b. Signature and title of certifier MID D31826 1-12-12 hard 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD LINTHICUM $M \cdot D \cdot$, $7601 \cdot OSL$ 7601 OSLER DRIVE TOWSON, MD 21204

State Registrar 32. Registrar Signatu

State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Catherine E. Toepfner 3:00 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner more ranklin square Hospita oseda 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours 220-64-6086 56 Yrs **Director** 1 □ M 2 🕱 F Feb.4,1955 MD show 10c. City, Town or Location 10d. Inside City Limits at Director "natural", or items 23a or 28a-f s edical Examiner must be notified Baltimore Middle River 1 ☐ Yes 2X No MD 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral USA 14 Nakota Court 21220 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black White etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married þ 1 ☐ Yes 2 XNo Specify: White Specify: 3 X Widowed 4 ☐ Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturn any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Free, Catherine (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Director of Nursing Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Vera Olderwurtel Harry Tatum Mays Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Middleway Road Baltimore MD 21220 Rita Ohle /sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 1/23/12 Baltimore MD Donation 3 Donation Balto. Mu 21. Signature of Juneral Salvio Lic Name and Address of Facility 300 MAce Ave. Balto Connelly Funeral Home of Essex 22. Name and Address of Facility 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) tomea Medical e to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-transi Cause (Disease or injury Cute Reno and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Lirector After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Fctopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ ER/Outpatient 3 DOA 1 🔽 Inpatient 2 🗌 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 20a Certifier Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check з 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 8 00053694 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 31. Date filed (Month, Day Year)

JAN 2 0 20 2 32. Regis rar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles Anthony Thomas 2012 \mathbf{P}^{M} January 11:07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5143 Shookstown Road Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Months Days Min. (Month, Day, Year) 220-82-9236
Usual Residence of Dece Director 1 ▼ M 2 □ F Yrs. 50 3-8-1961 MD show or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Frederick MD Frederick 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be Funeral 5143 Shookstown Road 21702 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Asbestos Removal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William A. Thomas Kathleen Pistorio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 5143 Shookstown Road Frederick, MD 21702 Kathleen Knight Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Bayview Crematory 1-20-2012 Dundalk, Maryland 21. Signature on Funeral Service Lider see Connelly Funeral Home of Dundalk, PA 7110 Sollers Point Road Dundalk, MD 21222 Was M01176 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CANCER Physician/ IVER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami Cause (Disease or injurathat initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached f the Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performe certificate 2 No Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Acciden 5 Pending work? 1 ☐ Yes 2 💢 No n 24 hours after death.

e Funeral Director; Ai bletely filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

within To the

(Check

only one)

29b. Signature and title of certifier

क्षप 31. Date filed (Month, Day, Year, 32. Registrar's Signature 2 0 2012

Name and address of person who completed cause of death (Item 23a) (Type, Print)

SIBTE A KAZHI, MD & LY TOIL HOUSE AVE - FREDERICK

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

01-16-2012

Co-bifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number D 4795

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

'	2	Ω	-	2	0	1	2	2
	4	U	1	4	U		4	J

oley rammen		1- For State Certificate Certificate			2012 UI	20
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Dea	
ledical Exami	ner	Les ley Kurch Tummerin		Month 12 January 11		m
		Fracility Name (if not institution, give street and number) Prince George's Hospital Center	4b. City, Town, or Location of Death Cheverly	1	4c. County of Death Prince George's	
C		Social Security Number	If Under 1 Year If Under 24Hrs	8 Date of Birth	(MM/DD/YYYY) 9. Birthplace (State of	or
Funeral Director			Months Days Hours Min		Foreign	
any.		10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside Ci	ty Limits
* .*	_	Maryland Anne Arundel Arnold			1 Yes 2	2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Country?	
the Natified	Oir	367 Buena Vista Avenue	21012	U	SA	
, MD 21215-0036 eant 2 should be filed within 72 hours after death with the Maryland eant 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at pace	Funeral		Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Bla White, etc.	ck,
after	by F	or Dates:	Yes 2 X No specify:		specify.White	
hours natu			ent's Usual Occupation (Give kind of most of working life, DO NOT use ret		16b. Kind of Business/Industry	
36 nin 72 e. than	ple		Socrotany		Law Firm	
5-0036 led within 72 h Tygiene. other than "n	Completed	17. Father's Name (First, Middle, Last)	Secretary 18.Mother's Name	e (First, Middle, Ma		
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than	Be (Robert Joseph Taminelli	Bettina	Jewel Cr	ook	
O 21 hould is man	٩		ng Address (Street and Number or			
MD and 2 sho alth and arm 27 is		Robert G. Taminelli/ Brother 2907 20a. Method of Disposition 20b. Place of Disp	7 Spring Lake Dri	ve David	sonville, MD 2103	5
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		1 Burial 2 X Cremation 3 Removal from State		Date	200. Eocalion - City of Town, State	
t. Pag tment trant:		4 Donation 5 Other Specify: HUntt Cre	ematory 1/1	7/2012	Waldorf, MD	
Baltimore, MD 21215-0036 Deparit. Pages I and 3 should be filed within 73 Department of Health and Mental Hygiere Important: If tiem 77 is marked other than injury or other traumatic event, the <u>Medical</u>			Name and Address of Facility Rob 5000 Annapolis Ro		vans Funeral Home	!
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter			t, shock, or heart Approximate	
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Alcohol and narcoti	c intoxication		Between Or Deat	
xaminer		or condition resulting in death) Due to (or as a consequence of):	C Incoming to			
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			-	
	miner	cause. Enter Underlying Cause (Disease or injury that initiated				
ecuted and transit	Exa	events resulting in death) Last Due to (or as a consequence of): d.				
	Medical	▼ UNPENDED ▼ AMENDED 2,3 per me g9 23a,27,28a-f,per m	23 1-20-12 vt e.g924 2-15-12 st	1		
ox 68760, sath certificate be ex attending physician for use as the burial	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
c 68 certifications use as	ciar	past 12 months?	Fetal death 3Ectopic pregnation Other (Specify)	ancy	Month Day Y	'ear
BOy e death the att	Physician/	1 Yes 2 V No 9 Unknown 9 Unknown	20101 (-)			
ires that the signed by the detache	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of de	
S, P					2 ✓ No 3 Probably 4 Ur	
cords law requi	Completed			24a. Was an autopsy	prior to completion of ca	
Zec The Ig cate h	ĕ			perform 1 V Yes 2		No No
certification:	Be	25. Was case referred to medical examiner?	26 Place of Death (Check			
of Vital Records, ng Physician: The law require this certificate has been similared director, page 2 should be	P	1 Yes 2 No lospital 1 Inpatient 2 ER/Outpatie			esidence 6 Other:	
ion of Vital teading Physician: leath. tor: After this certif the funeral director,	Ë	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 X No	unknown	w injury occurred	
S 4 5 3 5	cat	2 Accident Investigation Accident Investigation 28e. Place of Injury - At home, farm, str	25 pm	28f. Location (Str	reet and Number or Rural Route Num	per, City
Divious after our after our filled in	Certification:	3 Suicide Could not be	(front lawn)	or Town, Sta	te)367 Buena Vista	Ave.
Ho Fun Tely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	surred at the time, date and place, and	due to the cause	(s) and manner as stated.	
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investig	ation, in my opinion, death occurred a	at the time, date ar	nd place, and due to the cause(s)	
	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)	
00/4		Q durleit 18	O.C.M.E.		January 13, 2012	
2 part		30. Name and address of person who completed cause of death (Item 23a)	Paltimore Street Daltimore	MD 21222		
P	ate	Laron Locke MD. Assistant Medical Examiner 900 W. E 31. Date filed (Month, Day, Year) 32. Segistrar's Signature		NID 2 1223		
Regis	_	4444 0 0 0010 6	aled			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 5per FH, G925, 3/9/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ TERMA 6:17 1 Janvan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESAPEAKE HOSPITA BŁ AIR Social Security 15168 213-20-5160 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months Director 1 ☐ M 2 🏋 F 88 Mar. 20, 1923 Virginia Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location hours after death with the Maryland 10a. State must be notified at Director 1 Yes 2 No Bel Air Maryland Harford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò by Funeral items 23a 21014 USA 126 N. Hickory Avenue, Apt. 3 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No ō 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Shoe Manufacturer Line Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ဂ္ Mae (unk) Pendry Joseph Cline Mikel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 1105 Holmes Blvd., Tuscumbia, Alabama, 35674 Mikel Testerman / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury or Bel Air Memorial Gdn. 1/21/2012 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland permit. 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 36 Immediate Cause (Final 1ASTRO Phylician disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death 4 Pregnant a
9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No has filled in by the funeral director, page 2 certificate 2√ No 1 Yes Vital 25. Was case referred to medical 26. Place of Death (Check only one) or Attending Physician: Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 2 10 1 Yes မ 1/ npatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural Accident iniury 5 Pending work?
1 Yes 2 No Division Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29c. License number UPPER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 DIZEN 31. Date filed (Month, Day, Year) State Registrar

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 12:35 A M TOSSMAN LILLIAN 2012 01 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F Director 94 03/09/1917 213-12-8300 MD Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 X Yes 2 □ No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2434 W. BELVEDERE AVENUE 21215 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturar", or items 23s any injury or other traumatic event, the Medical Examiner must gones. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. þ 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ DAVID HALPERIN MARY HORN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 RIDERWOOD STATION, TOWSON, MD PENNY HARRIS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CEMETERY 01/18/2012 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility $\,$ SOL LEVINSON & BROS., INC. Mars Co 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Utriknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e 2 1□ Yes 2☑No 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1. Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours after death

To the Funeral Director:
completely filled in by the f

OV

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

State

Registrar

2434 W. BELVEDERE AVENUE BALTIMORE BABATUNDE AJANI MD 31. Date filed (Month, Day, Year) JAN 2 0 2012

PHYSICIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE GELLAT RIC

###Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

00064533

29d. Date signed (Month, Day, Year)

141)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 6:15 P M Physician/ Vines Month vester 1 2 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death County of Death **Examiner** Hospital Baltimore Balton Samaritan (000) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Min Days Hours **Director** 78 6 1933 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland the Medical Examiner must be notified at Director 1 X Yes 2 □ No 10g. Citizen of What Country? 23a or Funeral 21212 (0000) USA lona items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. /Secondary (0-12) life. DONOT use retired) College (1-4 or 5+) Kailroad orter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John William permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Vines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darden-Cousin 1324 Gorsuch Battimore, MD Mattie 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 117/2012 Balton MD 4 ☐ Donation 5 ☐ Other (Specify) Greenmount 22. Name and Address of Facility March F/H-East 1101 E. North Ave. 21. Signature of Funeral Service Licensee 21202 to make MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line CVD Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Yes 2 No detached 9 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, (mcer 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D0069314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mittal Prayafak 8813 Waltham Woods RA Bultmore MD 2/234 31. Date filed (Month, Day, Year) JAN 2 0 2012 32. Registrads Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day OS 9:39 AM William Whear January 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Sinai Hospital Baltimore Baltimore 5. Social Security Numberunk 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) **Director** 57 1 X M 2 □ F Sept 18, 1954 Ohio Usual Residence of Decedent shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified 1 XYes 2 No MD **Baltimore** 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be by Funeral 21210 700 Gladstone Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) photographer free lance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nancy Vaiers Paul Whear 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 853 W. University Pkwy #2B; Baltimore, MD 21210 Cynthia Whears - sister Health a permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) in State netery, crematory or other place) 22. Name and Address of Facility State Anatomy Board Director Ronal 655 W. Baltimore St; Baltimore, MD 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylican Metastatic squamous cell carcinoma of skin Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (of as a consequence on attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3

Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 4 Pregnant : 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 2 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tyes 2 No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) P26514 January 08, 2012 , M.D.

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINAL HOSPITAL OF BALTIMORE, 2401 W. BELVEDERE

Registrar's Signature

AVE, BALTIMORE MD 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Maryland		artment of F tificate of L		and M				2	01240
			Registrar 1. Decedent's Name (First, Management)	iddle, Last)		Cer	uncate of L	Jeaur		2. Date of Dea	Reg. No ath	,	_	3. Time of Death
h	Physicia Medic		OWEN	FRIED	MAN	WE	BER			JANUAR	Y 13	, 2012	ar	3:40 P M
	Examin	er	4a. Facility Name (if not institu		er)		4b. City, Town, or				4c	. County of D		- 10
an self	Funeral		8806 Brierly 5. Social Security Number		. Age (In yrs. la	st birthday)	If Under 1 Year		24 Hrs.	8. Date of Bird	th		Birthpla	ce (State or Foreign
	Director		217-83-8829	1 🗓 M 2 🗆 F	3	Yrs.	Months Days	Hours	Min.	Dec . 2			Country Shi	ngton D.C.
	and show l at	or	Usual Residence of Decede 10a. State 10b. Cou		10c. City	, Town or Lo	cation]					100	d. Inside City Limits
	Maryli 28a-f otifiec	Director	MD Moi	ntgomery			Chevy	Chase	3					1 X Yes 2 □ No
	ith the 3a or it be n	ral D	10e. Street and Number	n 4			10f. Zip Code	15				tizen of What		
	eath w	Funeral	8806 Brierly 11. Marital Status	12. Was Deced		. 13.	208 Vas Decedent of H	ispanic Orio	gin? (Spec	cify Yes or No-	T	nited 14. Race - A		
36	after de ", or il amine	by	1XXNever Married 2	If You Cive	2 X No		f Yes, specify Cuba		, Puerto F	Rican, etc.)		Black, W Specify:	hite, etc Whit	
00	e filed within 72 hours after death with the Maryland ttal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	3 Widowed 4 Divo	rced Year or Date		16a. Deced	lent's Usual Occup	ation			16h. K	and of Busine		
215	iin 72 h ie. han "n e Medi	omp	(Specify only h	nighest grade completed)	or 5+)	(Give	kind of work done of NOT use retired)	during most	of workir	ng				
121	filed within all Hygiene. d other than went, the M	Be C	0 17. Father's Name (First, Midd	do Last			Never W			(First, Middle,		Never	Wor]	ked
lano	l be file fental l rked o ric eve	To	Peter	Allen	Weber			Ruth			nife		Fr	iedman
Maryland 21215-0036	ige 1 and 2 should be file int of Health and Mental F t: If item 27 is marked of y or other traumatic evel		19a. Informant's Name/Relati				ng Address (Street a							
	F F		Peter A. Webe	er / Father	20b. Pl		Brierly sition (Name of	Rd.,		y Chase		D Z	081.	
moğ	Page 1 nent of ant: If ii		· ·	tion 3 Removal from S	tota CE	metery, cren	natory or other place ke Cremat	ory 0				ltsvil		
Baltimore,	permit. Page 1 s Department of H Important: If ite any injury or ot		21. Signature of Funeral Serv	te Licensee	Mo1530	7 8	app Funer 33 Gist A	s of Facility	łd Cr	emation				0910
	1		23a. Part 1. Enter the disease shock, or heart failure. L	e, or complications that ca ist only one cause on each	used the death h line.								A II	approximate nterval Between
200	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	d.			UKODYSTRO	PHY						Onset and Death
1	Examiner			Due to (o	r as a consequ	ence of):								
2	p ta	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a conseque	ence of):								
30	death certificate be executed the attending physician and ed for use as the burial-transit	Exan	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (o	r as a conseque	ence of):							+	· · · · · · · · · · · · · · · · · · ·
09	e be ey ysiciar ne buria	edical		L d									\perp	
876	rtificat ing ph e as th	Мес	IF FEMALE:											·
Box 687	is that the death certifica gned by the attending p be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?			death 3	Ectopic pregnand Other (specify)	Э				23d. Date of Month		ay Year
O. B	the de by the	hysi	1 Yes 2 No 9 Unknown	9 ☐ Unkno			(7,3/							
, P.O.	es that signed	by	Part II. Other significant con ENCEPHALOP	ditions contributing to dea			, ,		l.					cause of death?
ords	require been sig	letec		TIVE ENTERAL						24a. Was		-		y findings available
3ec	sician: The law is certificate has be lirector, page 2 s	Completed								autor	osy rmed?	prior death	to comp	oletion of cause of
tal	ertifica ector, p	Be C	25. Was case referred to med examiner?					ace of Deat	th (Check	A D	ARTI		100 -	
fVi	Physician: this certificaral director,	은	1 Yes 2X No	Hospital: 1 ☐ Ir 28a. Date o	patient 2 - E	ER/Outpatier 28b. Time of		4 LI Nu		me 5 Ty Resid			oe <i>cify</i>)	
o uc	nding ath. r; After ne fune	icate	1 🔀 Natural 5 🗌 Pe		, Day, Year)	injury	work			8d. Describe h	iow injur	y occurred		
Division of Vital Records,	or Atte frer des irrector	Certificate:		ould not be termined 28e. Place of building	f Injury - At hor g, etc. (Specify)	ne, farm, stre	eet, factory, office		2	28f. Location (S City or Tow			Rural R	oute Number,
Ö	To the Hospital or Attending Physician: The law requires that the within 24 hours atter death. To the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.		29a. Certifier 1X Certif	ying Physician: To the be	st of my knowle	edge, death o	occurred at the time	e, date and	place. an				stated	
	the Ho	Medical	(Check 2 ☐ Medic only one) 3 ☐ Certif	cal Examiner: On the basis ying Nurse Practitioner:	of examination	and/or invest	igation, in my opinio	n, death oc	curred at	the time, date a	ind place	, and due to tl	he cause	e(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of cer	tifier Bl	000) .	29c. License					te signed (Mo		
	•		30. Name and address of pers			, ,		3552			JA	NUARY	17,	2012
			MARIAM BLOOM	, M.D., 111			E. NW, WA	SHING	TON	D.C. :	2001	0		
	Sta Registra		31. Date filed (Month, Day, Yea		gistrar's Signatu	are San	News							

DHMH 17 Rev 06-2011

•			Plea	ise Type o						•		egible	e.		
*		For State Registrar		State	of Mar	-	•	artment of F tificate of L	Health and N Death	-	giene _{Reg. No.} 🤈		2	ΩL	24
Physicia Medi		1. Decedent's Name Jacque	,		Wils	son				2. Date of De Month Janua		Year 20	12	3. Time o	of Death
Exami		4a. Facility Name (if)							r Location of Death sville			unty of De			
Funeral Director		5. Social Security Nu 249-33-5	296	6. Sex 1 ☐ M 2 💢 F	7. Age (l	n yrs. last birthe	day) 'rs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	y, Year)		Country)	or Foreign
ryland -f show ied at	ctor	Usual Residence of 10a. State	10b. County		1	0c. City, Town				3737				I. Inside C	City Limits
ith the Ma 23a or 28a st be notifi	Funeral Director	MD 10e. Street and Num 7110 Eas		ing Str	eet	нуас	ts'	ville 10f. Zip Code 207	85	П	10g. Citizer	of What	Country		5 2 LJ NC
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Marrid 3 Widowed 4	ed 2 🔀 Man	12. Was Dec	edent Eve orces? 2 XNo				ispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Ar Black, Wh		.	
within 72 hours after giene. er than "natural", o , the Medical Ex-mi	Completed	(Spec	cify only highe	nt's Education st grade completed College (BA/BS	1-4 or 5+)	— ·	Give I ife. D	O NOT use retired)	nation during most of work nistrate		16b. Kind		ss Indu	stry	
2 should be filed th and Mental Hy 27 is marked oth traumatic event	To Be	17. Father's Name (F		.ast) .es Phil	lips	5	_		18. Mother's Nam	e (First, Middle, a Gene		name)			
d 2 should alth and M n 27 is mar er traumat		19a. Informant's Na	me/Relationsl	nip (Type, Print)		19b.			and Number or Run	al Route Numbe	r, City or To				
Dermit. Page 1 and Department of Hee mportant: If item any injury or othe		20a. Method of Disp 1 Burial 2 4 Donation		3 ☐ Removal from	n State	cemetery	, cren pe	sition (Name of natory or other place ake Cre	m. 1/20	Date 0 / 2012		svil	lle	, MD	
permit. Depart Import any inj		21. Sign and c Fun	eral Service I	XILM	3 <i>n</i>				^{ss of Facility} Fre						
Physician/ Medical Examiner		23a. Par 1. Enter the shock or heard Immediate Cause (Figure disease or condition resulting in death)	t failure. List o Final	aa	ach line.	e death. Do no	C	er the mode of dyin	g, such as cardiac	or respiratory an	rest,		lr Ir	opproxima nterval Be Onset and INCOME	tween
death certificate be executed the attending physician and led for use as the burial-transit	dical Examiner	Sequentially list cor if any, leading to im cause. Enter U. der Cause (Disease or i that initiated events resulting in death) L	injury	c		onsequence of									
ath certifi attending for use as	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 X g ☐ Unknown	nonths?		Birth 2 gnant at ti	pregnancy □ Fetal death me of death		Ectopic pregnand Other (specify)	су		230	d. Date of o		ay	Year
uires that the des r signed by the sild be detached i	by	Part II. Other signifi	cant condition	ons contributing to	death but	not resulting in	the u	nderlying cause giv	ven in Part I.		obacco use Yes 2 🗆				
The law require ate has been si page 2 should	Completed										an 2 osy ormed? 2 4No	death	to comp	oletion of	available cause of
ysician; The law requires is certificate has been sig director, page 2 should b	To Be C	25. Was case referre examiner? 1 Yes 2	d to medical	Hospital:	Inpatient	t 2 🗆 ER/Out	patier	LOth	lace of Death (Checer:	k only one)					
ial or Attending Physician; s after death. al Director: After this certific ed in by the funeral director,	Certificate:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	5 ☐ Pendir Investi 6 ☐ Could determ	gation not be	nth, Day, \	~ At home, farr	jury	work	y at	28d. Describe h	now injury oo	ccurred		oute Num	nber,
Hospit 4 hour Funerated fills	Medical		Medical E	Physician: To the examiner: On the ba	sis of exa	mination and/or	invest	tigation, in my opinio	on, death occurred a	it the time, date a	and place, an	d due to th	ne cause		anner stat
To the within 2 To the comple		29b. Signature and	itle of certifier	manm				29c. License D25	e number		29d. Date s	igned (Mo	nth, Da	y, Year)	12
V		30. Name and addre		nan, Md	920	00 Bas	il	Ct.ste	#200; L			20774	-		
Sta	te	31. Date filed (Marth	20 201		Registrar's	Signature	. 4								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Month}an 6, Physician/ 2012 1:45 AMM Cleo Weber Charlotte Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland 104 Wempe Drive If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Country 1 M 2 Q Months Hours Min Dec 15, ^{Year} 1925 Yrs **Director** 220-16**-**2600 86 Usual Residence of Decede 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits the Maryland must be notified at Director Cumberland MD Allegany 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 21502 USA 104 Wempe Drive items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify If Yes, Give Year or Dates Specify. "natural" Completed 3 XWidowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mae V. Wilson Walter William Hartman, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Priva Frostburg MD 21532 19a. Informant's Name/Relationship (Type, Print) Walter Weber son 20b. Place of Disposition (Name of cemetery, crematory or other place Sunset Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Date 1 KD Burial 2 ☐ Cremation 3 1 Removal from State 1/9/2012 MD Cumberland ☐ Donation 5 ☐ Other (Specify) Funeral Service Licen Signature 22. Name and Address of Facility Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Tones Medical resulting in death) Due **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and I-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopie pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 5 Other (specify) sate has been signed by the page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N after death.

Director: After this certificate 2 🗌 No Yes funeral director. 25. Was case referred to predical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home _2 🛂 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation filled in by the 1 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital within 24 hours a Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) D0066439 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Blanche Marromatis M.D

.12502 Willowbrook Rd., Str 300 Cumberland, MD2150

12-00282 Linda Winfield

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

inda vvintieid		1- For State Registrar	ate of Maryla		artment of <i>tificate of</i>		Mental H		eg. No. 201	2 0124
Physici Nedical Exam		Decedent's Name (First, Midd Linda	le,Last)	Winfie	-1 <i>a</i>	_		2. Date of Dea Month January 1	Day Year	3. Time of Death 1435 hrs
		4a. Facility Name (if not institution		mber)		4b. City, Town, or L	ocation of Death	January 1	4c. County of Dea	
Funeral		4807 Crowson Avenu 5. Social Security Number	e 6. Sex	7. Age (In yrs. la	ast birthday)	Baltimore If Under 1 Year	If Under 24Hrs.	8 Date of Bir	n/a	tirtholace (State or
Director		215-78-2615	1 M 2 XF		52 Yrs.	Months Days	+		Fore	
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locati	on				10d. Inside City Limits
Maryland 28a-f show 1 at once.	ō	MD n	'a		Balt	imore				1 Yes 2 No
e Maryl	Director	10e. Street and Number				10f. Zip Code		11	0g. Citizen of What Co	untry?
death with the Maryland or items 23a or 28a-f abo must be potified at once.	_	1519 N. Giln		edent Ever in U.S	S. 13. Wa	212 s Decedent of Hisp		ecify Yes or No	U.S.A.	erican Indian, Black,
or item	Funera	1 Never Married 2 Ma	1 Yes	2 X No		es, specify Cuban,			White, etc.	modif maidi, black,
ırs after t ural", t miner	à	3 Widowed 4 Div 15. Decedent's Education (Specific	orced if Yes, Give Year or Dates:			Yes 2 No		ork done	Specify: E	lack
72 hou	Completed	Elementary/Secondary (0-12)	College (1			ost of working life. I			Tob. Kind of Business	vindustry
5-0036 ted within 72 Hygiene. other than '	ФШО	10th Grade 17. Father's Name (First, Middle,	1 oct)		Prep	Food			Subway	
Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho injury or other traumatic event, the Medical Examiner must be positived at once.	Be	Allen Br	yant			18	Grace		Maiden Surname)	
D 2, should and Me 77 is marice	ဥ	19a. Informant's Name/Relations Diane Bryant		-)					ber, City or Town, Stat	
Baltimore, MD sernit, Pages I and 2 sho Department of Health and Important: Witem 27 in njury or other traumati		20a. Method of Disposition		20b. P	lace of Disposi	tion (Name of ceme	etery,	Date Date	zimore, M. 20c. Location - City o	
Pages Pages ment of tant: B		1 Burial 2 Cremation 4 Donation 5 Other Sp			rematory or oth -Site	• •	on 1/1	9/2012	Baltimor	e, MD
Balt permit, Departi Import		21. Signature of Funeral Service	Licensee	Vinn						ome, PA MD 21217
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that ca	used the death. I	Do not enter th	e mode of dying, su	uch as cardiac or	respiratory arre	st, shock, or heart	Approximate Interval
/Medical		Immediate Cause (Final disease or condition resulting in death)	a Cirrhosi	is and f	atty cl	nange of	the live	er		Between Onset and Death
nd!		Sequentially list conditions,	Due to (or as a	Ethano	1 abuse	e and Hep	atitis (C Infect	tion	
1"	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a c	consequence or)						
ecuted and transit	Exa	events resulting in death) Last	Due to (or as a d	consequence of):						
al -	Medical	X UNPENDED		3a-b,pt.	II,27,	per me,g9	925 3-7-	12 sm		
8760, ifficate be ng physic as the burn	Me.	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, o	utcome of pregna		al death 3	Ectopic pregnan	CV	23d. Date of deliver	y Day Year
Box 687, death certifics the attending plud for use as the	Physician/N	past 12 months? 1 Yes 2 No 9 V Unk	4 Pregna	nt at time of deat	<u>,</u>	er (Specify)			World	Day Pear
O. B at the d d by the		Part II. Other significant condition	9 OHMOV		sulting in the un	nderlying cause give	en in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
Vital Records, P.O. Box 6876 bytician: The law requires that the death certificat this certificate has been signed by the attending phat director, page 2 should be detached for use as the	ed by	Hypertensive	Cardiovas	cular D	<u>isease</u>			1 Yes	2 No 3 Pro	bably 4 🗸 Unknown
Cord law req has bee	Completed							24a. Was a autops perforr	y prior to	utopsy findings available completion of cause of
I Re n: The rtificate or, page		25. Was case referred to medical	1			26 Place of	f Death (Check or	1 ✓ Yes 2		es 2 No
Vita hysicia this cer	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 In	patient 2 E	R/Outpatient	7.00			Residence 6 🗸 Othe	r: Scene
After		27. Manner of Death 1 X Natural 5 Pendi	28a. Date o (Month, i	f Injury 2 Day,Year)	28b. Time of Inj	.	at Work? 2 s 2 No	8d. Describe ho	ow injury occurred	
visic or Atter fter dea Director in by th	Certification:	2 Accident Invest	igation	of Injury - At hom	ne, farm, street,	, factory, office build				ural Route Number, City
Dispital spours a meral I		4 Homicide determ	nined (Specify)					or Town, Sta		
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Medical	(Check only Certifying Ph)	vsician: To the best liner: On the basis of and manner sta	examination and	e, death occurre d/or investigatio	ed at the time, date on, in my opinion, d	and place, and d eath occurred at	ue to the cause the time, date a	(s) and manner as stat nd place, and due to th	ed. e cause(s)
L > F 3	ž	29b. Signature and title of certifier		/ 1	5	29c. License n			29d. Date signed (Mo	
	-	30. Name and address of person v	no completed cause	of death (Item 2)	3a)	O.C.M.	E.		January 11, 201:	2
		Russell Alexander MD.	Assistant Me	V .	,	V. Baltimore St	treet, Baltimo	re, MD 212	23	
Sta Registr	ite ar	31. Date filed (Mont) AN 2"0	2012 32. Re	strar's Signature	1. Sa	Kel			COME	
	_									

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 435 M Diane Pamela Young Januari Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner maryland N/A altimore General . Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In Funeral 8/3/195 Days 1 🗆 M 2 🗶 F Hours NY City 120-42-5865 60 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland Director Baltimore 1 X Yes 2 No MD N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 818 Newington Ave. Apt. B 21217 USA permit. Page 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Board of College (1-4 or 5+) Elementary/Seconday (0-12) 12th Teacher Education AA Degree Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Steve Young Margaret James 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anaja Thornton-Daughter 405 Bentalou St. Baltimore, S. MD 21223 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mt. Carmel Cemt. 1 Burial 2 Cremation 3 Removal from State 1/18/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H East 1101 E. Signature of Funeral Service Licensee Smette North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine to (or as a consequence of Cause (Disease or linjury attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending of the funeral Director. Division of Vital Records, P.O. Box 68760 as the IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown been signed by the should be detached 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 1 Yes 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 10 of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State

Registrar
DHMH 17 Rev 7/2009

12-00413				or Print in B								gible.		-	
John Charles Yo	-	iblood 1- For State	Stat	e of Maryland					Ment	al Hyg	giene		201	2	01245
		Registrar 1. Decedent's Name	o /Eiret Middle I	aet)	Cer	tificate c	Deati	n	· ···	12	Re . Date of Deal	eg. No.		2 Time	of Death
Physici Medical Exam		John Cha	rles Yo	ungblood			45 00 7				Month January 1	Day 4, 2012	Year County of Dear	171	12 hrs
		703 Lombai	d Court	give street and number			4b. City, T Abing	don				Ha	rford		
Funeral Director		5. Social Security N 317-18-29		Sex 7. Aç M 2 F	ge (In yrs. Ia	st birthday) Yr	Month:	s Days	If Under Hours	Min	8. Date of Bir July 3		Fore	ign	State or Holland
Ь		Usual Residence of 10a. State			Idon Oite	Town or Loca	41							Tana In	side City Limits
nd show an	-	Maryland	10b. County Harfo	rd		ingdon	ation .								Yes 2 XNo
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Nur	mber		l		10f. Zip	Code			10	0g. Citizer	n of What Co	untry?	
h the day		703 Lon	bard Co	urt			21	009				US	A		
th with	uneral	11. Marital Status 1 Never Marrie	ed 2 Marri	12. Was Deceden Armed Forces			as Decede Yes, specif				cify Yes or No ican, etc.)	- 14	I. Race - Ame White, etc.	rican Indi	an, Black,
er dea	ഥ	3 Widowed		1 Yes 2 ed If Yes, Give Year	No No	1	Voc 2	X No	enecify:			9,	pecify: Wh	i to	
urs aft tural" amine	d by			or Dates: only highest grade cor	mpleted)	16a. Decede	nt's Usual	Occupatio	n (Give ki				d of Business		
72 hor na "na al Exa	etec	Elementary/Seco		College (1-4 or		during r	most of wor	king life. [OO NOT u	ise retired	d)				
215-0036 be filed within 7 ntal Hygiene. riced other than ent, the Medica	Completed	8				Ins	truct						S. Gov	ernme	ent
filed v Hygi d oth		17. Father's Name						18			First, Middle, N	/laiden Su	ırname)		
212 ould be Menta marke	To Be	John C. 19a. Informant's Na				19b. Mailir	na Address	(Street	Unkn		ral Route Num	ber. City	or Town, Stat	e. Zip Co	de)
MD 12 shouth and 127 is 1		Barry D.				9					Aberd				
G, N I and Health item		20a. Method of Disp	oosition			lace of Dispo rematory or o	sition (Nam	ne of ceme			Date		cation - City o		
MOF Pages ent of nt: If		1 Burial 2 5		Removal from St	alci				orp.	1/19	/2012	To	wson,	Mary:	land
Baltimore, bernit. Pages I ar Department of Hee important: If ite		21. Signature of Fu					Name and				omas F	1	-		
0 20 4 1		Zail	ava 1	Midle)					Road	l, Abin	gdon	, Mary	land	21009
Physician			e disease, or cor ly one cause on	mplications that caused each line.	the death.	Do not enter	the mode o	of dying, s	uch as cai	rdiac or re	espiratory arre	est, shock	, or heart		een Onset and
Examiner	. 1	Immediate Cause (or condition resulting		a. Smoke Inhalati			uries co	mplicati	ing Hea	rt Dise	ase			1	Death
				Due to (or as a cons	equence or):								1	
	횰	Sequentially list con if any, leading to im cause. Enter Unde	mediate	Due to (or as a cons	equence of):									
.04	Examiner	(Disease or injury the events resulting in	nat initiated	c. Due to (or as a cons	equence of):								+	
ecuted and transit	al Ex	events resulting in	dodiny Last	d											
	dica	UNPENDED		AMENDED											
760 icate b physi	¥	IF FEMALE: 23b. Was decedent	pregnant in the	23c. If yes, outco	me of pregn	-			7				Date of delive	•	
Division of Vital Records, P.O. Box 68760, within 24 hours after death. The the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medic	past 12 months	?	1 Live birth 4 Pregnant at	t time of dea	th -	etal death Other (Spec	3 <u> </u>	_Ectopic	pregnand 	;y	M	onth	Day	Year
D. BO) t the death by the att				s contributing to deat	h but not re	sulting in the	underlying	cause giv	en in Part	: I .	23e. Did to	bacco use	e contribute to	the caus	se of death?
ords, P.O. w requires that th s been signed by should be detach	d by										1 Yes	2 🗌 N	No 3 Pro	obably 4	✓ Unknown
rds requir	e e										24a. Was a				dings available on of cause of
ecol he law te has	Completed				·						perfor	med?	death?		2 No
1 of Vital Rec Jing Physician: The l After this certificate I funeral director, page		25. Was case refer	ed to medical	<u> </u>			2		f Death (0	Check on					
Vita hysicia this co	To Be	examiner? 1 ✓ Yes	2 No	Hospital: 1 Inpatie	ent 2 🗌	ER/Outpatier	nt 3 D	OA O	ther ₄	Nursing I	Home 5	Residenc	e 6 🗸 Othe	er: Scene	
of Vi ing Physi After this		27. Manner of Death		28a. Date of Inju	ury (ear)	28b. Time of FOUND:	Injury 2		at Work?	Ιщ	8d. Describe h	now injury	occurred		
SiOr sttend death. ctor: y the	黛	2 Accident	5 Pending Investig	Jan 14, 2012		1712 hrs_			s 2 🗸 1						
Division of Vital Records, tall or Attending Physician: The law required and dear death. After this certificate has been silled in by the funeral director, page 2 should be	Certification:	3 Suicide	6 Could no	and the second			eet, factory,	office bui	ilding, etc.	L	or Town, S	tate)			e Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	8	4 Homicide 29a. Certifier		(Specify) Sir			irred at the	time data	and place	- 1	93 Lombard				
To the H within 24 To the F complete	Medical	Check only		ner:On the basis of exa	-										(s)
To wit	Me	29b. Signature and	title of certifier	and manner stated.			29c	. License	number			29d. Da	te signed (Me	onth, Day	Year)
		(a)	20 1	4010A	il			O.C.M	.E.			Janua	ary 15, 201	12	
- N	ŀ	30. Name and addre		o completed cause of								I			-
10.		Carol Allan,	MD Assis	tant Medical Exa	miner 9	-		Street, E	Baltimor	e, MD	21223				
Si	ate	31. Date filed (Mont	h Ray Year 2	32 Registra	ar's Signatu	ba	Make								

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #205 per FH in FCHD 175/F2 Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Day 15 28 PM Robert C Aloi 2.012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Many land Medical System

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year) 1 🕅 M 2 🗆 F Director 173-28-6878 77 Oct. 3, 1934 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City. Town or Location Director 28a-f Frederick 1 Yes 2X No Frederick Maryland 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 21701 10102 Statesman Court United States items death 12. Was Decedent Ever in U.S.
Armed Forces?
1 Ayes 2 No 1958- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify. 1965 'natural" Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Chemicals Chemical Engineer +4 traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o Carmella Petrone ၉ Dominick Aloi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10102 Statesman Court, Frederick, MD 21701 19a. Informant's Name/Relationship (Type, Print) of Health a item 27 is Francesca Aloi 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/7/2012 Department of Important: If it any injury or o once. $\frac{1}{7}$ Fort Steuben Wintersville, Ohio 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, MD own eart 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest snock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) amplication Medical Due to (or as a consequence of) Examiner strictive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of -transit Gastrointest and that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the buria Physician/Medical P.O. Box 68760 as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) for 1 in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe Records, heart failure, Diabete 2 No 3 Probably 4 Unknown 1 Yes page 2 should Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe this certificate has 1 ☐ Yes 2 Dlo 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospita 2 🗌 No Other: မ 1) Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify 27, Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred after death. Director: After injury (Month, Day, Year) ☐ Natural 5 Pending 1100 Fall from Stoo 2 Accident A M 1 🗌 Yes 2 🔀 No December 25, 2011 Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined To the Hospital within 24 hours a To the Funeral C completely filled Home Statesm Medical 1 Prising Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 21701 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100484 -5 January 2012

State Registrar

umms

MD

32. Registrar's Signature

22 South Greens St

Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Du

4

E

JAN 0

31. Date filed (Month, Day, Year)

,	Ġ	Ph. Ex	i ian Medica amine
man, Eugenia 1/1/2012 1449 PM	of Vital Records, P.O. Box 68760	ing Physician: The law requires that the death certificate be executed	ifter this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the buriar ansit

		ForState	State of Ma	ryland /	•		and Menta	al Hygie	ne	01017
		Registrar 1. Decedent's Name (First, Middle, Las	et)		Certificate	or Death	2. Dat	Reg.	No. 2 1 2	3. Time of Death
Physici Medi	cal		Eugenia	Blechn			Jan	nth	01, 2012	1449 м
Exami	ner	4a. Facility Name (if not institution, give	Hospital		4b. City, To	own, or Location o Bether			4c. County of Death	tgomery
 Funeral	Т	Social Security Number 6. S	7. Age	(In yrs. last bir			24 Hrs. 8. Date	e of Birth	g. Birth	place (State or Foreign
Director		577-20-9596 1 Usual Residence of Decedent	□ M 2 🗓 F	88	Yrs.	Days	1000	8/08/1	923 Wash	ington, DC_
and show	P	10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
Mary 28a-f otifie	irec	Maryland Montg	omery			Chevy Ch	rase			1 Yes 2 X No
/ith the 23a or st be r	ral	10e. Street and Number 8100 Connecticu	t Ananna /	n+ 51	10f. Zip 0	Code 2081	1 5	10g	. Citizen of What Could . S	•
eath w	Funeral Director	11. Marital Status	12. Was Decedent Ev	·	13. Was Deceder	nt of Hispanic Orig	gin? (Specify Yes	or No-	14. Race - Americ	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	b	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🛛 N If Yes, Give	0		y Cuban, Mexican No Specify:	, Puerto Hican, e	etc.)	Black, White, Specify:	etc. White
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed	15. Decedent's E		16a	. Decedent's Usual	Occupation		168	b. Kind of Business In	
121, thin 72 ne. than "	mo	(Specify only highest gra	College (1-4 or 5+)	(Give kind of work life. DO NOT use n	done during most etired) U Hygeni			Day	ıtal
d 2: led wit Hygie other ent, tt	Be	17. Father's Name (First, Middle, Last)	4		venu	1	er's Name (First, I	Middle, Maid		<u> </u>
/lan d be fil Mental Mental arked rtic ev	은	Avram	Schumache	L			, ,		Wagenheim	
Alan, should and h is ma		19a. Informant's Name/Relationship (7)			-				y or Town, State, Zip	
e, N and 2 a Health Iem 27		Robert K. Blechmo	an - Son		1-25 Yello of Disposition (Name		3Lvd.,#1		rest Hills c. Location - City or To	, NY 11375
Page 1		1 🔀 Burial 2 □ Cremation 3 🔀 4 □ Donation 5 □ Other (Specif		cemete	ery, crematory or oth	er place)			ashington,	
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other		21. Signature of Funeral Service Licens	9 MO	1564						Home, Inc.
m goras		23a. Part 1. Enter the disease, or comp	ngu		<u> 111800 Ne</u>	<u>ew Hampsh</u>	ure A ve	.,Sil	ver Spring	, MD 20904
~ Physician/		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.				cardiac or respira	atory arrest,		Approximate Interval Between Onset and Death
Medical		disease or condition resulting in death)	a. Acute Due to (or as a		dial Infa	irction			-	
Examiner	ri G	Sequentially list conditions,	b							
B _ B	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	consequence	oli):					
Box 68760 death certificate be executed ne attending physician and add for use as the burial facility	I Exa	that initiated events resulting in death) Last	Due to (or as a	consequence	of):					
ate be	edical		d							
Se ding	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Date of deliv	rery.
VITAI RECORDS, P.O. BOX 68, ysician: The law requires that the death certific is certificate has been signed by the attending I director, page 2 should be detached for use as	by Physician/M	in the past 12 months? 1 Yes 2 X No	1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown		h 3 Ectopic pre 5 Other (spec				Month	Day Year
Kecords, P.O. The law requires that the ate has been signed by the page 2 should be detach	Phy	9 Unknown Part II. Other significant conditions co		not resulting	in the underlying ca	use given in Part I	220	a Did tabaa	co use contribute to t	ha cause of death?
S, F	d by	Acute Renal Fai	Ü			g				bably 4 🌠 Unknown
w request speed	plete	Respiratory_Fai	lure				248	a. Was an	24b. Were auto	psy findings available ompletion of cause of
//tal HeCO sician: The law r certificate has b irector, page 2 sl	Completed	Metabolic Acido	sis				1 [autopsy performed ☐ Yes 2 [X	? death?	•
Ital sician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🌠 No	Hospital:			Other:	h (Check only on	e)		
Of V g Phys er this eral di	e: To	27. Manner of Death	28a. Date of injury	28b.	tpatient 3 DOA Time of 28c	. Injury at			e 6 Other (Specif) njury occurred	2
lon eath. or: Aft the fur	fical	1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		rear)	njury M	work? 1 \(\text{Yes} \) 2 \(\text{D} \)	No			
DIVISION OF tal or Attending Pr rs after death. al Director: After th ed in by the funeral	Certificate:	4 Homicide determined	28e. Place of Injury building, etc.	- At home, fa 'Specify)	rm, street, factory, o	office		ation (Street or Town, St	and Number or Rural ate)	Route Number,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	29a. Certifier 1 X Certifying Phys	ician: To the best of m	y knowledge,	death occured at th	e time, date and p	place, and due to	the cause(s	and manner as state	ed.
the Hi thin 24 the Fu	Med	only one) 3 L Certifying Nuks	Practioner: To the be	mination and/o	ledge, death occurre	d at the time, date	curred at the time and place, and du	ue to the cau	se(s) and manner as st	
P \$ P 8		29b. Signature and title of certifier	tempalret	-	29c. L	icense number.	68405		Date signed (Month, January 01	
'		30. Name and address of person who c			Type, Print)	7000	-		Junuary 01	, 2012
<u>. </u>		Jesus David Gueva	vra-Nieto,	M.D.,	8600 Old	Georgeto	own Road	, Bet	hesda, Mar	yland 20814
Sta Registr		31. Date filed (Month, Day, Year) JAN 0 4 2012	2. Registrar's	Signature	parket					
DHMH 17 Rev 7/2	009				<u></u>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12-00035 Donald Blizzard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nald Bl	izzard		State of Maryland / Department of 1-For State Certificate of			2012	2 0 1 2 4
Р	hysicia	_	Registrar	Dodan	2. Date of Deat		3. Time of Death
edical			Donald David Blizzard		Month January 2,		0515 hrs
1			4a. Facility Name (if not institution, give street and number) 7807 W. Hill Road	 b. City, Town, or Location of Death Mt. Airy 		4c. County of Death Carroll	
	neral ector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min		th(MM/DD/YYYY) 9. Birth Foreign .5, 1942 Cou	
			220-42-8379 1XM 2 F 69 Yrs. Usual Residence of Decedent		Dec. 1	.5, 1942 555	
	w any		10a. State 10b. County 10c. City, Town or Location	n			10d, Inside City Limits
land	ns 23a or 28a-f show be notified at once.	ģ	Maryland Carroll Mt. A		140	og. Citizen of What Coun	1 Yes 2 X No
ie Mar		Jirec		10f. Zip Code			•
with th		ral		21771 Decedent of Hispanic Origin? (Sp			
death	or item	Funeral Director	1 Yes 2 X No	s, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
safter	n'al",	à.	or Dates:	Yes 2 No specify: 's Usual Occupation (Give kind of v	work done	Specify: Whi	
72 hour	Hygiene. other than "natura the Medical Examin	Completed		st of working life. DO NOT use reti		TOD, KING OF BUSINESSAI	idusii y
036 ithin	ene.	d E		visor		Gas Com	ıpany
21215-0036 ruld be filed within 7	Health and Mental Hygiene. item 27 is marked other tl r traumatic event, the Med	Be Co	17. Father's Name (First, Middle, Last)	18.Mother's Name	,		
D 21215-0036 should be filed within 72 hours after death with the Maryland		ToB	Howard Garfield Blizzard Dorothy Nowlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
				est Hill Road			
			20a. Method of Disposition 20b. Place of Disposit 1	tion (Name of cemetery, er place) Jan	Date uary	20c. Location - City or 1	Town, State
Baltimore, permit. Pages 1 au	Department of I Important: If injury or other		4 Donation 5 Other Specify: Stauffer (21. Signature of Funeral Service Licensee 22. No	Crematory 4,	2012	Frederick,	
D berm	Dep I			. Ridgeville Bl		Funeral Home Airy, Mary	
Physician		. /	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.				Approximate Interval Between Onset and
	aicai niner		Immediate Cause (Final disease or condition resulting in death)	ase			Death
			or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	e to (or as a consequence or):			
p	physician and the burial - transit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, topital or Attending Physician: The law requires that the death certificate be executed		edical	UNPENDED AMENDED				
7760 ficate b			IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fets	al death 3 Ectopic pregna	ancv	23d. Date of delivery Month Di	ay Year
Box 6876 death certificate the attending phy		iciar	past 12 months? 4 Pregnant at time of death 5 Oth	er (Specify)		I Monar	uy Tour
. Bo	signed by the at be detached for	Physician/N	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the ur	oderlying cause given in Part I	23e Did to	bacco use contribute to the	he cause of death?
P.O.		Ď	Chronic Alcoholism	asilying cass given in tact.		2 No 3 Proba	
ords w requi	been	Completed			24a. Was a autops	sy prior to co	opsy findings available ompletion of cause of
Zec The la	cate has page 2 s	E			perform	med? death? 2 No 1 Ves	2 No
	ath. or: After this certificate the funeral director, page	Be	25. Was case referred to medical examiner? Hospital: Input in the property Input in the property	26.Place of Death (Check		Desidence of Com-	0
of Vi		5	1 Yes 2 No Figure 12 Elvouparient 2 Elvouparient 2 27. Manner of Death 28a. Date of Injury 28b. Time of In	0 55.t		Residence 6 Other:	2ceue
O D O		ţį	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident Investigation (Month, Day, Year)	1 Yes 2 No			
Division of Vital Records, all or Attending Physician: The law require	rs after d al Direct led in by	Certification	3 Suicide 6 Could not be determined (Specify)	, factory, office building, etc.	28f. Location (S or Town, St	Street and Number or Rur tate)	al Route Number, City
	Funer Funer ely fil		4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
To the	within 2 To the complete	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.		at the time, date a		
		Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mon January 2, 2012	ui, Day, real)
	,	30. Name and address of person who completed cause of death (Item 23a)					
1	1/2		Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223				
	St Regist	tate trar	31. Date filed (Month, Day, Year) 2012 32. Registrar's Signature	Kal			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day a Year Physician/ Jennifer Lee Browning 3:00 PM Januar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Hours 191-68-5333 39 Director 1 🗆 M 2 🔀 F June 5 1972 Pennsylvania show 10d. Inside City Limits 10a. State 10c. City, Town or Location items 23a or 28a-f sho her must be notified at Director 1 Yes 2 No Greencastle PA Franklin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17225 10658 Worleytown Rd. U.S.A. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ral", or iten | Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Yes. Give Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Citigroup Instructional Designer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H item 27 is marked ot rother traumatic ever ည Robert F. Stackhouse Nancy M. Greene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 10658 Worleytown Rd. Greencastle, PA 17225 Gary Lee Browning/Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date j 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) ± 5 Department of Important: If any injury or Cedar Hill Cemetery 1/14/2012 Greencastle, PA Signature of Funeral Service Licensee 22 Name and Address of Facility
Zimmerman And Son Funeral Home Inc. Marten 45 S. Carlisle St. Greencastle, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SITUCIC Physician/ SEPTIC disease or condition Medical resulting in death) Examiner ULMOUNT EMBOLISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury PREUMONIA Exami the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical RONAL Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ♀ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by MYOCAMOIA INFAMCTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? COAGULOPATITY 24a. Was an autopsy performed PEJPIRATOKI 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 K Natural 24 hours after death Funeral Director: A ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completely f (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

WIZDY

29c. License number

0006200

11116 MODICAL Campus Rd. Hage

29d. Date signed (Month, Day, Year)

21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Williams Conner 01 12:07 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Charlotte Hall 7825 Keech Road If Under 24 Hrs 8. Date of Birth **Funeral** Social Security Number 6 Sex 7. Age (In yrs. last birthday, If I Inder 1 9. Birthplace (State or Foreign 1 M 2 X Days 02/18/1917 **Director** 579-01-5993 94 South Carolina Usual Residence of Deceder show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No MD Charlotte Hall Charles ms 23a or must be n ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7825 Keech Road 20622 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. 5 þ 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Tes 2 No Specify White Specify: "natural" Completed 3 X Widowed 4 Divorced er than "natur , the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene. 12 Communications Secretary f Health and Mental Hygie item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Sue Richbourg James Butler Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Sherry Conner/Daughter-in-law 7825 Keech Road Charlotte Hall, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Crem 1/6/2012 Charlotte Hall, MD Signature of Funeral Service Lice 22. Name and Address of FacilityBrinsfield-Echols Funeral Home P. A M00817 Welle Charlotte Hall, MD 20622 30195 Three Notch Road 23a. Part 1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 0 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Year Day Pregnant at time of death Unknown e Hospital or Attending Physician: The law requires that the 124 hours after death. e Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Amelianown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy completed filled in by the funeral director, page 2 2 🗆 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: ၉ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Besidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at work? 1
Yes Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending Accident 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the vithin 2 the only one) 3 🗌 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of per

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) Type, Pf

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ enes Month 1707 2012 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 1ASOSDWA Menico Mer. Tils WOSTIN Social Security Numbe Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 X M 2 - F Min 01/28/1920 Director 218-16-2823 91 Yrs MD Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Washington Clear Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21722 USA 11745 Big Pool Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u> Milling Machine Operator</u> Truck Assembly Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Julia Boden Raymond W. Creek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD21722 <u>Sherry</u>Shives/Daughter 11430 Big Pool Road Big Pool, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 01/07/2012 Little Orleans, MD Price-Wesleyan Cem. 21. Signature of Funeral Service License 22. Name and Address of Facility 141 West Main Street M00260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, if of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List solv one cause on each lipe. Immediate Cause (Final Onset and Death Physician/ SPIROTION disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an prior to cor death? autopsy perform Yes 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Mer. 165 ממכטיאר BASA

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death EATON Physician/ 1650M DA 20012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 05/29/1947 MARYLAND Director 218-80-0259 64 Usual Residence of Decedent or 28a-f show 10b County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD QUEEN ANNE'S GRASONVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 228 EVANS AVENUE 21638 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced WHITE Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) TILGHMAN COOK ELIZABETH STANT permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORMA CRITES / DAUGHTER 601 OWENS ROAD, QUEEN ANNE, MD 21657 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date WOODLAWN MEMORIAL 1 X Burial 2 Cremation 3 Removal from State 01/10/2012 EASTON, MD 4 Donation 5 Other (Specify) 21. Signature of Fune al Service Licensee 22 Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause is each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed burial-transit Due to (or as a consequence of) Physician/Medical Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 2 No Linknown 9 Unknown ģ Part II. Other significant conditions contributing to death but mot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Label Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Ves 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending Accident Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier who corpoleted cause of death (Item 23a) (Type, Print) MAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year 10:47 A M Elizabeth Kathleen Fallin January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel South River Health Center Edgewater Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 579-20-2699 91 **Director** 1 □ M 2 🕱 F 07/21/1920 Virginia Usual Residence of Decedent 10c. City, Town or Location Director 10a. State 10d. Inside City Limits notified 28a-f 1 Yes 2 🗙 🖈 lo Maryland| Anne Arundel Edgewater 10e. Street and Numbe 10f. Zip Code 10g. Citizen of USA of What Country? ms 23a or must be n Funeral 3639 Fontron Drive 21037 "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify White Specify Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Store the Packer 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H ည William Rust Cooper Carrie Loudelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Irving Fallin / Husband 3639 Fontron Drive Edgewater, MD 21037 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 듓 Department of Important; If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Kalas Crematory 1/7/12 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home PA 2973 Solomons Island Rd. Edgewater, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a cons the burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?
1 Yes 2XXNo Month Day Year signed by the at Id be detached for Pregnant at time of death g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2 autopsy perform death? Yes XX No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t XX Natural 5 Pending work? filled in by the Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mal 100 0070693

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

MAHBOOB

JAN 0 4 2012

SYED 31. Date filed (Month -03-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 3Day 2012Year Physician/ 6:00 а.м Otto Fleischman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Caroline Homestead Manor Denton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** Days Hours 1 M 2 X F Months April Day Year 1916 North Carolina 214-10-7802 95 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Cambridge 1 X Yes 2 No MD Dorchester with the Mar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21613 USA 2482 Cambridge Beltway permit. Page 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black White etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) tire center owner/operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) ည Martha Yates James Franklin Church 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 102 Shawnee Circle, Cambridge, MD 21613 Kav F. Ruark daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1/7/12 Cambridge, MD Dorchester Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. re of Funeral Service Licensee K 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final arter Ptaysician/ Cotonary Medical resulting in death) Due to (or as a consequent e of) Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examine Due to (or de a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) signed by the aid be detached for a I I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? death? r this certificate had director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be A531540 examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Living 은 funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Manner of Death 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Registrar

Medical

(Check

only one)

Melinda 31. Date filed (Month, Day, Year)

3 🗆

JAN 0 5 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

3683 Chap

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00053255

ent Road Preston MD 21655

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day January 9, 2012 1925 Albert Fox Norman 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) St. Mary's Leonardtown St. Mary's Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) 6. Sex Months Days Hours Min. 1 **3** M 2 □ F 579-58-6686 64 05/20/1947 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10h County 1 ☐ Yes 2 No St. Mary's Leonardtown Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20650 USA 39606 St. Mary's Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Surveyor City Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Fox James Alyce Ida Mundt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 39606 St. Mary's St., Leonardtown, MD 20650 Lucheria A. Fox/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Mattingley-Gardiner 01/11/2012 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Home Crematory 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650 Signature of Funeral Service Licensee Pardener 23a. Parr 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AURTIC VALVE REMOTE disease or condition resulting in death) Due to (or as a consequence of): RE6 AORTIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ENTRICULAR LNSTANT Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 ØNo 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, certificate has briector, page 2 st this certifical After

Physician

Examiner

Funeral

Director

28a-f show

rat", or items 23a or 28a-f shov

"natural",

traumatic event, the Medical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic event, Item any once.

Physician

/Medical

Examiner

Funeral Director

þ

Completed

Be

မ

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

たんつい

FOX, Norman Albert

/Medical

Medical Certification: To after death Director: , d in by the f

within 24 hours aft To the Funeral Di completely filled in 10) pm State Registrar

Examine Physician/Medical δ Be Completed

> and manner stated. 29b. Signature and title of certifier

6 Could not be

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10,2012

MJ 20637

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24035 THREE NOTICH ROAD HOLLYWOOD SHAH MD

31. Date filed (Month, Day, Year)

2 Accident

3 Suicide

29a, Certifier

4 🔲 Homicide

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dea January 1 2012 and 3:40 A M Godfrey Physician/ Lois Eadie Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's District Heights 6909 Kipling Parkway If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months **Director** 251-40-1672 1 M 2 XX 87 S. Carolina 09/10/1924 Yrs Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State Director 1 Yes 2XXNo District Heights Prince George's Maryland 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number ō items 23a or ner must be n Funeral **USA** 20747 6909 Kipling Parkway death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, an "natural", or itel Medical Examiner Armed Forces?

1 Yes 2 X X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2xxNo Specify: Specify: 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. d other than " event, the Mer Elementary/Secondary (0-12) College (1-4 or 5+) Medical Registered Nurse vears Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental ! Rickenbaker ဂ Carey Α. Eadie Pressley permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11290 Lord Baltimore Dr. Issue, Maryland 20645 Preston Godfrey / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1/4/2012 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 21. Signatur 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final CEREBRAL VASCULAR ACCIDENT Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if an leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Other (specify) 4 Pregnant a Pregnant at time of death Yes 2XX No been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2XXNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? 1 Yes 2 No 1 Yes 2 X No After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) **X** \(\text{X} \) residence 6 \(\text{Other} \) Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certificate: To 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No injury XX Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29ax Xertifier (Check Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

15 State

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year) **JAN 0 4 2012** Registrar

29b. Signature and title of certifie

Mickey Mills

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

MD

ack

6400 Marlboro Pike District Heights, MD

Date signed (Month, Day, Year) 3,

2017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 01, Physician/ 2012 7:25 am Dorothy Guttman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months (Month, Day, Year) Davs 345-16-8124 Director 1 M 2 XF 86 Yrs Illinois 01/26/1925 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City. Town or Location must be notified at Director 1 Yes 2 No Silver Spring Maruland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 23a Funeral U.S.A. 20904 3158 Gracefield Road, Apt. #223 item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🄀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Public School System 5+ Special Education Director Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ Sarah Riskin Emil Tarnopol 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3158 Gracefield Rd.,#223, Silver Spring,MD 20904 item 27 Newman Guttman - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 Durial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 01/10/2012 Brentwood, Maryland 4 Dpnation 5 Other (Specify) e of une sil Se 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Angiosarcoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Lung Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury use as the burial-tran attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No cate has page 2 s funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director, A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1/2/2012 06894

Registrar DHMH 17 Rev 06-2011

State

NUS

address of person who completed cause of death (Item 23a) (Type, Print) FITTE

gunas.

3001 Hospital Dr., Cheverly, Maryland 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JANUARY 4:20 201 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth Days Hours Min. 12^{Day} Sountry) Maryland Director 214-28-2260 Oct. 81 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No Maryland Frederick <u>Walkersville</u> 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 8803 Biggs Ford Road 21793 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 X Widowed 4 Divorced Year or Dates White Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natur lury or other traumatic event, the Medical. lury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Frederick Health Dept. Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Viola Staley Harry Russell Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Graham/ Daughter 8815 Biggs Ford Road, Walkersville, Maryland 21793 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/5/2012 Hope Cemetery Woodsboro, Maryland. ral Service Lice Stauffer Funeral 1621 Opossumtown Prederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of impury attending physician and for use as the burial-transit death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attendin d be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Pregnant at time of death 2 NO 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has performed' death? or Attending Physician: The 1 Yes 2 No Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No ပ္ 1 🗌 Yes 1 Linpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Mannar of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) ortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and son who completed cause of death (Item 23a) Type Print) 30. Name and addre Frederick MD

DHMH 17 Rev 7/2009

State Registrar Date filed (Month)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9928 6-26-12 yt. State of Maryland / Bepartment of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death January 3 Day 2012 ear Physician/ **HOFBERG** 1:30 A Mildred Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 215546×1896 7. Age (In vrs. last birthday) Funeral Hours (Month, Dav. Year) Director 1 □ M 2 🗘 F 95 March 19, 1916 Washington, DC 10c. City, Town or Location 10d. Inside City Limits at 10a. State Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5555 Friendship Boulevard 20815 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: "natural", 3X Widowed 4 □ Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s z should be filed within 7 Ith and Mental Hygiene. 77 is marked oth marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Owner and Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ David Feldman Bessie Burka 19b, Mailing Address (Street,ard Number or Rural Route Number, City or Town, State, Zip Code) 6521 Sunny Hill Court, McLean, VA 22101 19a. informant's Name/Relationship (Type, Print) Susan Pittleman, Daughter 1 and 2 s of Health a item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State Date permit. Page 1:
Department of I
Important: If it
any injury or of 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) (ing David Memorial Garden 01/05/12 Falls Church, VA 21. Signatur - Fu era Servi Torchthsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) right middlecerebral artery Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica **Division of Vital** 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☐XNo Other: ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work?
1 Yes 2 No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d, Date signed (Month, Day, Year, 29c. License number Chilewer D.O. 1167490 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christine Castro, D.O., 8600 Old Georgetown Road, Bethesda, MD 31. Date filed (Month, Day, Year) State JAN 04 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month 20:35 anuary 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death HODKINS 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months **Director** 222-44-4380 54 1 X M 2 🗆 F Yrs. JUN 2, 1957 MILFORD, DE Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits notified at Director **DELAWARE** SUSSEX COUNTY 19947 1 X Yes 2 □ No GEORGETOWN 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r Funeral with 1 107 CEDAR STREET 19947 USA items death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner rmed Forces Black, White, etc. 0 1 Never Married 2 X Married þ 2 🗌 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1988 1 ☐ Yes 2 X No Specify: Specify: BLACK "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 MAINTENANCE MECHANIC **COUNTY GOVERNMENT** traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 REGINALD I. HAZZARD BETTY L. HAIRSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i (SPOUSE) SANDRA HAZZARD 107 CEDAR ST., GEORGETOWN, DE 19947 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Donation 5 - Other (Specify) OLD HICKORY CEMETERY JAN 7,2012 LINCOLN, DELAWARE uneral Service Licen 22. Name and Address of Facility 19966 WATSON FUNERAL HOME PO BOX 125 MILLSBORO, DE MO 1361 had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. 3a. Part 1. Enter the diser shock, or heart failure Approximate Interval Between Onset and Death , or complications Immediate Cause (Final Artherosclerotic Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dusito (or as a consequence or) Exami burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 the attending IF FFMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Pregnant at time of death 1 Yes 2 No ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed been 24b. Were autopsy findings available 24a, Was an ate has autopsy performed? prior to completion of cause of death? certificate 2 🗌 No 1 Yes Director: After this certific Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No Accident
Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and t 29d. Date signed (Month, Day, Year) RES-000

DHMH 17 Rev 06-2011

State

Registrar

Registrar's Signature

600 North Wolfe Street, Baltimore Maryland 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 0 5 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 9:15 Gail Marie Hendley Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15600 Flatbill Court Charles Waldorf 9. Birthplace (State or Foreign Country) NJ 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Month, Day, Yea 0/05/193 Days 1 🗆 M 2 😾 F Months Hours **Director** 579-48-6291 76 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at with the Maryland Director or other traumatic event, the Medical Examiner must be notified 1 Yes 2 V No MD Charles Waldorf ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15600 Flatbill Court 20601 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature." 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 🔽 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US Elementary/Seconday (0-12) College (1-4 or 5+) 12 Contracting Officer Public Health Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Edward Esther Bertha Jones Hammerstone Hammerstone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15370 Secret Hollow Place Waldorf, MD 20601 Tracey McInerney /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veteran's Cet 1/18/2012 Cheltenham, MD 22. Name and Address of Facility Brinsfield-Echols Funeral Home P. 21. Signature of Funeral Service Licenses M00817 Layton C 30195 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 10 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to him addate cause. Enter Underlying Cause (Disease or linjury Examiner Date to for set a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 You

9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has lirector, page 2 s autopsy performe 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural work?
1 Yes 5 Pending 24 hours after death Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

6) RMP

31. Date filed (Monti

50

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Box 68760

Division of Vital Records,

Eileen Gemmell. 31. Date filed (Month, Day, Year)

JAN 04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP,

3160 Gracefield Road, Silver Spring, Maryland 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ennara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** che Care enter 6. Sex 1 M 2 □ F If Unde 8. Date of Birth 9. Birthplace (State or Foreign last birthday 7. Age (in vrs. **Funeral** Davs Min. (Month, Day, Yo Months Hours 481 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ¥Yes 2 ☐ No ilMingto death with the Mar 10e. Street and Number 10g. Citizen of What Country? Funeral 8 а 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Ves 2 No 1945 Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 🗹 No If Yes, Give Year or Dates. Specify: Black "natural" 3 ₩Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) onstruction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kennar Page 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of B 1 Warial 2 Cremation 3 Removal from State injury or Beckwith 4 Donation 5 Other (Specify) (PMetery 22. Name and Address Facility Signature of Funeral Service Licensee Pi Funeral Henry MD.21613 lashington St 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Oyear eth levoscievotic disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Dulmona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) signed by the a Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiomyo Records, 1 🗌 Yes 2 🗌 No 3 Probably 4 Unknown plnous been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 🗌 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 100 Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural injury 5 \square Pending 2 🗆 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 🖫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5 ress of person who completed cause of death (Item 23a) (Type, Print) Cambridge ohnson 100

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland	l / Depa <i>Cer</i>	rtment of H	ealth and Me Death	ental Hygien		01264
1	Physicia	an	1. Decedent's Name (First, Middle, La Nayab J.	st) Khan					ay 2012	3. Time of Death 7:25 p _M
1	/Medic	_	4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death	Jan. I	c. County of Death	
	LXdiiiii	C1	15610 Oak Glen			Hughesv		С	harles	
4	Funeral Director		5. Social Security Number 6. S 0 0 3 - 8 2 - 0 7 5 9	6ex 7. Age (In yrs. Ia 1□ M 2 F 6 4	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Yea 1/3/194	r) Cou	place (State or Foreign intry) i a
	and		Usual Residence of Decedent 10a. State 10b. County _	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Maryl Ff sho	tor	Md. Charle	s Hug	hesvi	11e				1 ☐ Yes 2 🖾 No
	ilied within 72 hours after death with the Maryland Hygiene. thar than "natural", or Items 23a or 28s-f show int, the Medical Evanding must be notified at	Funeral Director	10e. Street and Number 15610 Oak Gler	Circle		10f. Zip Code 20637	7		Citizen of What Cou	intry?
0	fter deat ritems	Funera	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🏋 No			ispanic Origin? (Spec n, Mexican, Puerto F	ify Yes or No- ican, etc.)	14. Race - Amer Black, White	, etc.
9500-61212	ural', o	by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		Yes 2 No	Specify:			sian
7	n 72 h ''natu	jete	15. Decedent's E (Specify only highest gra	ade completed)	16a. Deced (Give life. L	ent's Usual Occupa kind of work done of OO NOT use retired	ation during most of workin f)	g 16b.	Kind of Business/li	ndustry
7 7	d withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4		emaker	, 		Home	
	be de la	To Be C	17. Father's Name (First, Middle, Last Sirajuddin) Khan			18. Mother's Name Saliha	(First, Middle, Maide Begum		
Maryland	should ind Men ind marke	2	19a. Informant's Name/Relationship (19b. Mailin	a Address (Street	and Number or Rural			ip Code)
	s 1 and 2 should f Health and Mer Item 27 Is marke othar traumatic			on	15610	Oak G1	en Circl			,Md.20637
Baitimore,	Pages 1 anneat of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	THOUSON TOUS STATE I		sition (Name of natory or other plac	1 1		Location - City or 1	
	permit. Pages. Department of the Important: If ite any injury or of once.		*4 □ Donation 5 □ Other (Special 21. Signatural Fineral Service Lices	y) Mar		d Nation	nal Jan.		urel, M	
g	Department Department on interest in position on inter) (and	de Malle			edy St N			
		l e	23a. Part f. Enter the disease, or comshock, or heart failure. List only	plications that caused the death. one cause on each line.	. Do not ente	er the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	, u.	letas	tases				Onsor and Doali
	Examiner			Due to (or as a consequence to be a consequenc		Carcinor	na of	Jterus		
	- PL	ner	Sequentially list conditions, if any, badding to inneclate cause. Enter Underlying Cause (Disease or injury	b. Exie to (or as a conseque		J 4 1 0 1 11 0 1				
_	be executed ician and burial test	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	ence of):					
100	ate be executed nysician and he burial-	caiE		d	,					
B	certificate Iding phys	-	IF FEMALE:							
C. Box	 requires that the death certifica been signed by the attending ph should be detached for use as th 	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of decenting	death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
s, T	s that t ned by e detac	by Ph	Part II. Other significant conditions	contributing to death but not resul	lting in the ur	nderlying cause give	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Sign	requires that een signed b nould be deta							1 🗆 Yes	2 No 3 Pro	babiy 4 🖔 Unknown
I Kecord	The lay ate has page 2	Completed						24a. Was an autopsy performed	prior to c	topsy findings available ompletion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death		_	
0	Phy rthis raid	. To	1 Tyes 2 No 27. Manner of Death	28a. Date of Injury	R/Outpatien 28b. Time of	28c. Injun	er: 4 Nursing Hom	e 5 🔀 Residence 8d. Describe how in		ify)
0	Attending F ir death. ector: After by the funera	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Worl	k? Yes 2 □ No			
UIVISION	after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, str	eet, factory, office	2	8f. Location (Street City or Town, St	on (Street and Number or Rural Route Number, Town, State)	
	To the Hospital or Attendin within 24 hours after death. To the Funarat Director: Att completely filled in by the fun	Medical C	29a. Certifier (Check only one) 1 Vertifying Pl 2 Medical Example	nysician: To the best of my know miner: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the tin restigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cause d at the time, date a	o(s) and manner as and place, and due	stated. to the cause(s)
	To the To the comp	Ň	29b. Signature and title of certifier	shi. M.D.		29c. Licens		29d. [Date signed (Month	Day, Year)
			30. Name and address of person who Anwar Munshi	completed cause of death (Item, Md. 130 Hos	23a) (Type, Spita	Print) 1 Rd. P	rince Fr	ederick	, Md. 2	0678
5	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signate	ure					
	Registr	ar :	JAN 04 2011	L. Dever B.	400					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ Daniel Lee Leonard 2012 0410 Medical 4a. Facility Name (if not institution, give street and numb 4b. City. Town, or Location of Death 4c. County of Death . Examiner SAL13641-1 4100m 100 RAGIONAL PENINSULA rdical If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Country 213-16-8143 **Director** 1 🛛 M 2 🗆 F 84 Jan. 10, 1927 Maryland Usual Residence of Deced 28a-f show 10a. State 10b. Count 10d. Inside City Limits notified at 10c. City, Town or Location Director 1 Yes 2 No Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be r Funeral USA 21801 633 Arthur Street death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. ed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 Married XYes 2 Maryland 21215-0036 1 LA Yes 2 L. No If Yes, Give World War Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Car Care, Inc. Mechanic llth and Mental Hygie is marked other event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည pe t. Page 1 and 2 should be thrent of Health and Mentrant: If item 27 is marke injury or other traumatic Elmer Leonard Nettie Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 633 Arthur Street - Salisbury, MD 21801 Barbara Leonard Stanford/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place 1 Burial 2X Cremation 3 Removal from State 01/09/2012 Salisbury, MD Donation 5 Other (Specify) Salisbury Crematory Salisbury, of Funeral Service 22. Name and Address of Facility Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 . Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Lause Luisease or injury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical The law requires that the death certificate be Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month 5 Other (specify) Pregnant at time of death signed by the aid be detached for 4 ☐ Pregnant 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 🗌 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform has page 2 • Hospital or Attending Physician: The 24 hours after death. • Funeral Director: After this certificate I Yes 2 No 1 Yes 2 No 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🕅 No 1 🗌 Yes ၉ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Magner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Investigation Accident in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 2

State

Check

only one) 29b. Signature and title of certifie

Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

Registrar

29d. Date/signed (Month, Day, Year)

MW SHAREDK SACISBORY MD21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ - INGERACH Month 0800 7072 ILLIAM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 4908 Abbott Drive Temple Hills Prince George's If Under 1 Year Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year If Under 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year) Director 579-26-6597 1. M 2 - F Yrs Usual Residence of Decedent /27/1926 <u>Washington</u>. DC or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Temple Hills 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? r items 23a or ner must be n Funeral 4908 Abbott Drive 20748 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces? Retired
1 M Yes 2 USAR 1974
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner r 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Salesman Ice Cream Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H item 27 is marked ot William L. Lingebach, Sr. Elisabeth Sipple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley M. Lingebach/Wife 4908 Abbott Drive, Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State tof :**∓**: 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 1/5/2012 Suitland, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur Funeral Service Licensee 6160 Oxon Hill Rd. Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ ELO 045 Medical resulting in death) Due to or as a consequence of Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of: Cause (Disease or injury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death this certificate has been signed by the a ral director, page 2 should be detached f 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 2 20 V

Registrar

State

31. Date filed (Month, Day, Year)

W 441

HEFENSE

Name and address of perspn who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 3, 2012 Year Physician/ Betty Jean Liller 9:12 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Mandrin Hospice Harwood If Under 1 Year If Under Months Days Hours 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday, **Funeral** Director 236-46-8018 1 M 2 X F June 12,1931 West Virginia 80 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director Annapolis 1 Yes 2 □ No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21403 1211 Hesselius Court filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify. Completed 3 X Widowed 4 □ Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene.

item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) the <u>Receptionist/Funeral Assistant</u> Funeral Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Page 1 and 2 should be Esta Cleo Weimer Earl Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 12913 Creamery Hill Dr., Germantown, MD Dana R. Liller / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/9/12 Oakland, Maryland Garrett Co.Mem.Gardens 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Signature of Funeral Service Licenses 147 Duke of Gloucester St., Annapolis, MD 21401 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Qnset and Death** Immediate Cause (Final Physician/ 200 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last eral Director. After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 2 No death? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other Second DICE Hospital: ျ 1 🗌 Yes 2 **Yo**No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at within 24 hours after death.

To the Funeral Director. After 1 WiNatural iniury 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2017

Registrar DHMH 17 Rev 06-2011

15

State

31. Date filed (Mon

enge Har

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Varrott

JAN 0 4 2012

445

Registrar's Signati

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ 12:00 p M January 1, Leach Pauline Gaither Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Brooke Grove Rehab. & Nursing Center Montgomery Sandy Spring Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) If Under **Funeral** Hours Min (Month, Day, Year) 213-09-4426 Director 1 🗌 M 2 🕱 F 94 Dct. 18, 1917 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location Director Examiner must be notified 1 Yes 2 No MD Sandy Spring Montgomery OF 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1635 Hickory Knoll Road 20860 USA items ; death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. "natural", or p 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ည Paul William Gaither Mamie Ruth Barger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or other NY 11375 Dale Leach/Son 102-11 62 Road, Forest Hills, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Jan 6, 2012 Edge Hill Cemetery Charles Town, WV 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. MO1503 500 University Blvd. W., Silver Spring. 23a. Part 1/Enter the disease, or complications τηαι σαυσω shook, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 9 Unknown signed by the a Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably X Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No 1 ☐ Yes 2 🔀 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ည 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury work?
1 \(\sum \) Yes 2 \(\sum \) No X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, rpletely filled in by 4 Homicide determined City or Town, State) Medical 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier sasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the 3 Certifying Nurse Practity ner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ertifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjamin/Avrunin,

JAN 04

Year)

31. Date filed (Month, Day,

MD

Registrar's Signature

D08381

#209

18111 Prince Philip Drive, Olney. MD 20832

January 3, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month / FAN 0600M OROTHY 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spa Creek Center Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Dav. Year, 577-36-7007 **Director** 1 M 2 F May 14, 1930 Washington, DC 81 Usual Residence of Decedent 28a-f show d Mental Hygiene. marked other than "natural", or items 23a or 28a-f shov matic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 No Maryland | Anne Arundel **Annapolis** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 28 Bunche Street 21401 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates. Korea Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Prince George's life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) County Schools 12th Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce. Bertha Campbell Hugo J. Goetz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jillian B. Catterton/ Friend 28 Bunche Street, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Cemetery 1/5/12 Davidsonville, MD neral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Dooth S Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year been signed by the a should be detached To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title of certif 29c. License number 29 Date signed (Month, Day, Year, (V) 41-1 o completed cause of death (Item 23a) (Type, Prin Name and address of persol NNAPOLIS MOLIYOI 31. Date filed (Mor 32 aistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death MARTIN DONALD Month Physician/ HOYE 2012 **A**. M January 7:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mennonite Fellowship Home Washington Hagerstown If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex Age (In yrs. last birthday) **Funeral** Min. Nov. 11 1919 1 X M 2 🗆 F 217-32-5097 92 Maryland **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD. Washington Hagerstown 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12349 Huyett Lane 21740 U.S.A. 72 hours after death with Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc 1 \square Never Married 2 \square Married 1 ☐ Yes 2 🗓 No If Yes, Give Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 ☒ Widowed 4 ☐ Divorced "natural" Year or Dates Department of Health and Mental Hygiene Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Feed & Supply Co. Elementary/Seconday (0-12) Page 1 and 2 should be filed within Owner/Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ J. Ira Martin Lydia Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois S. Horst/Daughter 18851 Airview Dr. Hagerstown, MD. 21742 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Reiff Mennonite 1 X Burial 2 Cremation 3 Removal from State 1/17/2012 Cearfoss, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 21. Signature of Funeral Service Licenses H. Marte 45 S. Carlisle St. Greencastle, PA 17225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CHRONIC OBSTRUCTIVE PULMONARY DISEASE Immediate Cause (Final Physician/ 5 YEARS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No After this certificate has been signed by the funeral director, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown KIDNEY DISEASE CHRONIC 24b. Were autopsy findings available prior to completion of cause of 24a, Was an performed STENOSIS To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and the 11110 MEDICAL

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

leted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nea 2012 Doroth Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Charles 2488 Quadrille aldor 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 X Months Hours Min New York. 08/28/1924 Director 084-18-7682 87 Usual Residence of Decedent show with the Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f 1 ☐ Yes 2 X No MD Charles Waldorf 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be injury or other traumatic. Funeral 2488 Quadrille Court 20602 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government 12th Administrative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Carty Mary Brodmerkel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Deena Richey / Daughter 27085 Lenore Court, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Brinsfield-EcholsCrem 01/10/2012 Charlotte Hall, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. Jan #M00174 30195 Three Notch Road, Charlotte Hall. MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, others failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Varian Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Medical death certificate be P.O. Box 68760 IF FEMALE Physician/ 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown Hakaowa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director: After this certificate has b autops page 2 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 09-2012 D0063028

4 teme State

Danche Williams MO 12070 Oki Line Ctr #302 Waldorf Md 20602
Date filed (Month Day Year) 0 2012 June B. June

6. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Year :20 a.m.M F. Julius Owens January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 X M 2 - F Days Min 12/10/1932 Maryland Director Yrs 220-26-6945 79 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No Maryland St. Mary's Leonardtown items 23a or ner must be n ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22610 Lawrence Avenue 20650 United States death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. er than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 XMarried filed within 72 hours after al Hygiene. d other than "natural", or 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other 1 any injury or other traumatic event, th Flight Test Engineer U.S. Government 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Freeman Owens Mary Lillian Armsworthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Owens/Wife Box 1136, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 01/10/2012 Valley Lee, Maryland George Cemetery 21. Signatur Tuneral Servic Acrossee
Edward N. Brinsfield 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 Jr. M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause 💉 each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Due to jor as a consequence of cause. Enter Underlying Exami Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the hurial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death 1 L Yes 2 L g C Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 Z 25. Was case referred to medical examiner?
1 ☐ Yes 2 📉 No 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1. Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signa ure and title of certific 29d. Date signed (Month, Day, Year,

5) pml State

Registrar

DHMH 17 Rev 7/2009

25365 Point Lookout Road, Leonardtown,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

II M.D

William D. Boyd,

, Day, Year) JAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ANUARY 2012 12:26A.^M **PHILLIPS** MILDRED Τ. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WILLARDS WICOMICO 8656 BETHEL ROAD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2**XX**F Hours MARCH 18 MARYLAND 1917 Director 94 216-10-1837 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2XXNo WICOMICO MARYLAND WILLARDS 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8656 BETHEL ROAD 21874 USA items death \ 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 9 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify Specify: WHITE should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", Completed 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LORENZO CLARA WILKINS TUBBS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth a Important: If item 27 is any injury or other tra CLIFTON F. PHILLIPS/SON 8834 BETHEL RD., WILLARDS, MARYLAND 21874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Dopation NEW HOPE CEMETERY 1/7/12 WILLARDS, MARYLAND 5 Other (Specify) 21. Sign were funeral Service License 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physiciani 400 Medical resulting in death) Due to (or as a consequence of): Examiner ust Teurion Sequentially flot our diffunc, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine and -transit Physician: The law requires that the death certificate be executed burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig Completed Chuna Kidney Disene 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: 4 \square Nursing Home 5 Aesidence 6 \square Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XNatural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Veleu m. mldado D001684

Registrar DHMH 17 Rev 7/2009 DRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIVERSIDIZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Louise Cross Polk 20/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** comico 0 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 X F Months Hours Min 260-40-3228 Yrs 02/09/1929 Director Georgia Usual Residence of Decedent or 28a-f shov 10b. County be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director 1 Yes 2 X No Maryland Wicomico Parsonsburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21849 USA 5883 Forest Grove Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or itel the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Julia Esther Gilbert Leavy Coleman Cross and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5881 Polk Lane, Parsonsburg, MD 21849 19a. Informant's Name/Relationship (Type, Print) Wade K. Polk/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Other (Specify) 1/7/2012 Forest Grove Cemetery Parsonsburg, MD 4 Donation 5 D 22. Name and Address of Facility Holloway Funeral Home Professional Association del Salisbury, MD 21804 Snow Hill Rd., 23a. Part 1. Enter the disease, or consectations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MALIGNANT BLADDERS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to lor as a consequence of cause. Enter Underlying Exam signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 100 24a Was an has page 2 Hospital or Attending Physician: The 24 hours after death.
Funeral Director: After this certificate I funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 TNO HOSPICIZ 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Natural 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature le of certifier 29 c. License number 29d. Date signed (Month. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANBURYUND

State Registrar 31. Date filed (Mont

1300

32 Registrar's Signature

1733

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thomas Parker 2012 William 10:54 P^M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Westminster Carroll Hospice Dove House 5. Social Security Number 8. Date of Birth
(Month, Day, Yea
June 6, 9. Birthplace (State or Foreign Country)
VA **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Days Hours 1 ₹ M 2 □ F 64 215-46-0840 Director 947 Usual Residence of Decedent shov 10c. City, Town or Location Finksburg ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director Carroll MD 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2252 Baltimore Blvd. 21048 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify. If Yes, Give "natural", 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Agnes Hagerty ည Horace B. Parker 19a. Informant's Name/Relationship (Type, Print)
Christina Parker - Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2252 Baltimore Blvd., Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremations 1/16/2012 Hampstead, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee. ^{22. Name and Address of Facility}Pritts Funeral Home & Chapel, PA 412 Washington Rd., Westminster, MD 21157 412 Washington Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition * Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 2 🗆 No Yes 2 No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 XNo Hospital Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident (Month, Day, Year) 5 Pending 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie ar 30. Name and address of person who completed cause of d

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 20 12 Eugene 7:00 P M Recchion Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1502 Florence Road Airy Howard 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Days Hours Director 194-09-9120 1 X M 2 🗆 F Yrs 1918 93 Pennsylvania Usual Residence of Decedent or 28a-f show e notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 X No Maryland Howard Mt. Airy 10e. Street and Number 10f. Zip Code 5 ms 23a or must be r 10g. Citizen of What Country? Funeral 1502 Florence Road 21771 United States iral", or items a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 K No Specify. White "natural" 3
Widowed 4 Divorced Year or Dates. WW II Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Recchion Amanda Udi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise E. Recchion / Wife 724 Kerr Street Pittsburgh, Pennsylvania 15220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 3, 2012 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Mt. Airy, Maryland 21771 8 E. Ridgeville Blvd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Myocardia disease or condition Medical resulting in death) **Examiner** pertensio Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Due to for as a co sequence of Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a d for use as the burial Physician/Medical IF FEMALE: of delivery Day signed by the at d be detached for ute to the cause of death? by ☐ Probably 4 ☐ Unknown

requires that the death certificate be Division of Vital Records, P.O. Box 68760

e Hospital or Attending P 124 hours after death. e Funeral Director: After the

Completed ၉ Certificate:

3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date Mont
art II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contrib
		24a. Was an autopsy performed?	24b. We pri de o 1
5. Was case referred to medical	26. Place of Death (Check	only one)	

			24a. Was an autopsy performed?	prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner?		26. Place of Death (Check of		
1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ D	OA Other: 4 Nursing Hom	ne 5 🛚 Residence 6	Other (Specify)
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury M	28c. Injury at work? 1 Yes 2 No	3d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	y, office 28	8f. Location (Street and City or Town, State)	Number or Rural Route Number,
29a. Certifier 1 X Certifying Physi	ician: To the best of my knowledge, death occurred a	at the time, date and place, and	due to the cause(s) an	d manner as stated.

29b. Signature and tit le of certifier 03585

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of mick covil-doc

501 N. Frederick Avenue Leszek Karowiec, M.D. Gaithersburg, Maryland 20877

Registrar

g

(Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Larry Victor Simmons 1241 PM 2012 aryor Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cambridge General Hospital Dorch If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 1948 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1**▼** M 2 □ F Maryland Director 218-50-1849 63 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Dorchester East New Market 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5517 Mount Holly Road 21631 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ş 1 Never Married 2 X Married Baltimore, Maryland 21213-0036 1 Yes 2 No Specify: white Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) superintendent electric contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Victor Simmons Melva Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy H. Simmons wife 5517 Mount Holly Rd., East New Market, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State East New Market Cem. 4 ☐ Donation 5 ☐ Other (Specify) 1/5/12 East New Market, MD ure of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Mocar Medical Examiner Due to (or as a consequence of) Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence ot): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending place as the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Day 2 No Yes been signed by the sahould be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown demia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy perform Yes 2 No 1 Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မ 1 Inpatient ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28h. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🕍 Natural 5 Pending Accident 1 Yes 2 🗌 No Investigation 24 hours after deau Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month TIMOTHY KIRK STUFFLEBEAN 745 M Medical 20/2 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HICOMICO GIONAL Age (In yrs. last birthday 6. Sex If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 339-56-5737 **Director** 1 🖾 1 2 🗆 F 49 **ILLINOIS** 12/9/1962 Usual Residence of Decede 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector notified 28a-f WICOMICO **SALISBURY** 1 ☐Xes 2 ☐ No MARYLAND Ö o 10e. Street and Number 10f. Zip Code ems 23a or r must be 10g. Citizen of What Country? Funeral 304 MILL POND LN., APT. 138 21804 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ō ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: WHITE "natural" 3 Widowed 4 Nivorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) RETAIL STORE MANAGER Ith and Mental Hygie
27 Is marked other
r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LAWRENCE BENJAMIN STUFFLEBEAN, JR. JANETH CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau JANETH MOGG / MOTHER 2317 OLD PLANK ROAD, CHESTER, IL 62233 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State SEFFERSON BARKACKS NATIONAL 01/12/2012 4 ☐ Donation 5 ☐ Other (Specify) MEHLVILLE, MISSOURI CEMETERY 21. Signature of Fundal 22. Name and Address of Facility NEWCOMB AND COLLINS FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 2161 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Anoxis One t and Death Physician/ En ceph alopathy disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 25ch enic Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical requires that the death certificate be P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Dav Year ed by the a 1 ☐ Yes ∠ ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law After this certificate has page 2 performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work? 1 \(\sime\) Yes 2 🗌 No reral Director: A Accident Investigation 3 Suicide 4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completely filled Medical

DHMH 17 Rev 06-2011

Registrar

29a. Certifier (Check

only one) 29b. Signature and title

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cinderella MD

Year, JAN 06 06 Miltor

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

alis bury

29d. Date signed (Month, Day, Year,

29c. License number

Please Type or Print in Black Indelible 1914. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2012 SARAH REGINA SMITH 7:45 Medical A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Days Hours Min. 09/18/1928 Director 83 PENNSYLVANIA 203-22-8983 Usual Residence of Decedent Show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 X No MD QUEEN ANNE'S GRASONVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 608 OYSTER COVE DRIVE 21638 UNITED STATES death v 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 1 Never Married 2 Married within 72 hours after þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Completed Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME is marked other Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WILLIAM SCHNEIDER ELIZABETH MCANDREWS injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 BERNADETTE SMITH / DAUGHTER 608 OYSTER COVE DRIVE, GRASONVILLE, MD 21638 tem 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) ALTON CEMETERY 01/07/2012 GALLOWAY, OHIO 21. Signature of Funeral Service Licensee 22 Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 114. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death
36 HOURS Physician/ SEPTIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner **PYELONEPHRITIS** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) E. COLI burial-trar Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Month Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛣 No 3 🗆 Probably 4 🗆 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page performed?
1 Yes 2 No death? certificate 1 ☐ Yes 2 🛛 No Division of Vital the Hospital or Attending Physician: completed filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗶 No Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. Investigation М Accident Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

D. O.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2001

KEITH GOULET

31. Date filed (Month,

H0070482

MEDICAL PARKWAY, ANNAPOLIS, MD 21401

1/3/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 ear Physician/ Month January Francis Joseph Sanders Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Charlotte Hall Charlotte Hall Veterans Home If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 91 1920 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Min 1 🕅 M 2 □ F February Director 318-18-2874 Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland |St. Mary's Valley Lee 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20692 United States 19596 Piney Point Road 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married be filed within 72 hours after 1 Yes If Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Security Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Francis Sanders Helen King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20692 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. PO Box 305, Piney Point Road, Valley Lee, Maryland Bernadette Trossbach-Niece Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 01/09/2012 Charlotte Hall, MD. 21. Signature of Funeral Service Censee

Edward N. Brinsfield 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650 M000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ALZHEIME DISEASF disease or condition , Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Yes 2 No g | Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION ESSENTIAL Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check or

				1 Yes 2	No	1 ∐ Yes 2 ∐ No				
rred to medical	26. Place of Death (Check only one)									
Hospital: 1										
5 Pending Investigation	tion		28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred						
6 Could not be determined	1 220 Diago of Injury - At h		ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
2 Medical Exam	sician: To the best of my know iner: On the basis of examinations se Practioner: To the best of m	n and/or investigation, i	in my opinion, death occurred	at the time, date and I	place, and	due to the cause(s) and manner	state			
d title of ertifier		2	9c. License number	290	d. Date sigi	ned (Month, Day, Year)				
enter	, MD]	D0067788		1 . 0	06.2012				
	completed cause of death (Iter	7 (31 /)	Hall Road, C	harlotte	Hall,	MD 20622				

01280

9:38 PM

10d. Inside City Limits

Onset and Death

Year

Day

1 Tes 2 X No

IllTTTOis

1+1

ne Hospital or Attending Pi n 24 hours after death. Ie Funeral Director: After th

State Registrar

completed filled in by

မ

Certificate:

Medical

2 4 No

1 Yes

27. Manner of Death

1 Natural

☐ Accident ☐ Suicide

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

(Check

LEENA

29b. Signature and title of ertifier

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ernest Junior Socks 12,2012 429M anuery Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Meritus Medical Center Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days (Month, Day, Year) 217-30-5795 **Director** 1 XM 2 - F Yrs March 26,1935 76 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 X Yes 2 No Maryland Washington Hagerstown 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21740 U.S.A. 804 Washington Ave. or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1X Yes Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify. Specify. "natural", White 3 Widowed 4 XDivorced Year or Dates. Army event, the Medical 16a Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Welder Crane Company 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Elizabeth King Ernest Richard Socks injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a 804 Washington Ave. Hagerstown, Maryland 21740 Ronald Lee Socks (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott January 1 D Burial 2 X Cremation 3 Removal from State Smithsburg, Maryland Smithsburg Crematory 4 Donation 5 Other (Specify) 18, 2012 21. Signature of Funeral Service Licensee MO1414 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Promisian/ welke disease or condition resulting in death) Medical Examiner Thrombosis Unknown Sequentially list conditions, Hary, leading to mineulate cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed athroscler and -trar Due to (or as a consequence of) resulting in death) Last burial physician s the burial Physician/Medical P.O. Box 68760 as the attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? ģ Month Day Year Pregnant at time of death g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pneumoma Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed Embolism 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? obstructive lung Disease 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Yes ည 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 44996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boonsboro 21713 Lappans Rd MALIK MA 20311 lan 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Julia Ann Smith Day 12 2012 Physician/ Month 615 Medical an 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagers town Washington . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 🗆 M 2 🛶 F Days Hours April Pay 1, 1941 212-38-9907 **Director** Mary land 70 Usual Residence of Deceden shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Washington Boonsboro 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19 School House Circle 21713 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural" 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Operator Finacial Institute Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clarence Stottlemyer Beatrice Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46 Stanford Rd. Hagerstown, Md. 21742 Cathy J. James (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. Smithsburg Crematory Smithsburg, Md. 2012 . Signature of Funeral Service Licen 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 6my o patt Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth
Pregnant
Unknown signed by the atte Dav Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, i Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending iniury work? Accident Suicide Investigation 2 No Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOLOURI JANNIND State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 14 2012 12:15P M Anna Drucilla Schriner /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Frostburg Allegany 104 Wright Street 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-09-1926 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 🔭 F Days Hours Mary Land 85 Director 216-22-7171 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show 2 should be filed within 72 hours after death with the Maryla and Mental Hygiene is marked other than "natural", or items 23a or 28a-f show raumatic event, it is "madical Experiment mast bur Affiled an raumatic event, it is "madical Experiment mast bur Affiled an 1 ☐Yes 2 No Directo Allegany Frostburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21532 U.S.A. 104 Wright Street Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: \$ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Sarah C. Schriner John Schriner ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
72 S. Water Street Frostburg, MD 21532 19a. Informant's Name/Relationship (Type. Print) Anne Wehler friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 1-16-2012 St. Michael Cem. Frostburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sowers Funeral Home, MO0547 Sousces 60 W. Main Street Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Endstage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed Exami s been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 s autopsy performed of Vital 1 ☐ Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 Natural

2 Accident 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated

31. Date filed (Month, Day, Year) 2 0 2012

29b. Signature and title of certifier

wowerksh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 Britis walch Rd Cumberland MD 21502 WONSOCKSHIN MD 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

00055325

29d. Date signed (Month. Day, Year)

Jan 16,2012

		Ple					ndelible artment o							e.		
		For State Registrar	Oto		iai y iai i		tificate (_	Reg. No	201	2	0128	14
Physicia	an	1. Decedent's Name (First, Middle DIMIT 105		2222							2. Date of De Month	ath Da		ear	3. Time of Death	M
/Medic	al	4a. Facility Name (If not institution		opan c			4b. City, Tov	wn, or Lo	cation of E	Death	gnuar	γ / 4c.	County of I		023cA	VI
Examin	er	Johns Hopkins Bay			_	r	Baltime									
Funeral Director		5. Social Security Number 326-54-3547	6. Sex 1 X M 2		ge (In yrs. Ia	ast birthday) Yrs.	ff Under 1 \ Months D		f Under 24 Hours	4 Hrs. Min.	8. Date of Bird (Month, Da 11/6/1	v, Year)		Birthp Count ree		gn
land ow t		Usual Residence of Decedent 10a. State 10b. County			10c. City	y, Town or Lo	ocation		_	-				1	0d. Inside City Limit	its
e Mary 8a-f sh ified a	Director	Maryland Anne	Arunde	e1	An	napol:	is								1 XYes 2 □ N	10
th with the 23a or 28 st be not	al Dire	10e. Street and Number 1283 Graff Cour	rt, Apt	. 1B			10f. Zip-Co		21403	3		10g. Citizen of What Country? USA				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 🗓 Divorced	ed 1 If Y	s Decedent ned Forces' Yes 2 (Yes, Give ar or Dates:			Was Deceden If Yes, specify 1 ☐ Yes 2 ☐	Cuban, I	anic Origir Mexican, F Specify:	n? (Spec Puerto R	cify Yes or No- ican, etc.)	-	14. Race - A Black, N Specify:	White, 6		
72 ho 'natura dical E	Completed	15. Deceden (Specify only highes		leted)		(Give	dent's Usual C	done duri		of workin	g	16b. K	Kind of Busin	ess/In	dustry	
within iene. than he Me	ошр	Elementary/Secondary (0-12) 7th	Coll	ege (1-4 or	5+)	Own	DO NOT use r er	eurea)				R	estauı	ant		
al Hyg I other vent, t	Be C	17. Father's Name (First, Middle,						18			(First, Middle				-	
ould by Ment narkectaric e	2	Sotirios 1			siopan	т-	ing Address (S	Stroot and			rgia Ke			te 7in	Code	
nd 2 st lith and 27 is r r traun		Sotirios Tsiopa		•			Gentry									
es 1 ar of Hea fitem r other		20a. Method of Disposition 1 X Burial 2 □ Cremation				Place of Displemetery, cre	osition (Name matory or othe	of er place)		Da	ate	20c. L	ocation - Cit	y or To	wn, State	
t. Pag tment rtant: I		4 Donation 5 Other (S	pecify)				trios (2. Name and A		-	./5/:					Maryland	
Depar Impo any Ir		Signature of July 1	1								_				1D 21037	
Physician		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one caus	e on each li	ine.		ter the mode o	of dying,	such as ca	ardiac o	r respiratory a	arrest,		1	Approximate Interval Between Onset and Death Ony Stand	ing
/Medical Examiner		rooding in dealing		oue to (or a	s a consequ	uence of):										
- =	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying														
executed n and ial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):														
	edical		L d													
ertificat ng phy e as th	/Med	IF FEMALE:	000 16 11									Т			**	
sician: The law requires that the death certificate be certificate has been signed by the attending physicia lirector, page 2 should be detached for use as the but	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Ĺ 4 Ľ	Live birth	e of pregna 2 Fetal at time of de	death 3	☐ Ectopic pred ☐ Other (speci						23d. Date of Month		ery Day Year	
luires that signed by	þ	Part II. Other significant condition	ons contributii	ng to death	but not res	ulting in the	underlying car	use giver	n in Part I.		23e. Did				he cause of death? pably 4 🗌 Unknow	
he law rec s has beer age 2 sho	Completed										24a. Was auto perfo		pride	or to co ath?	ppsy findings availatempletion of cause of	
	Be C	25. Was case referred to medical examiner?							26. Place o	of Death	(Check only o			,		
Physic this ce	မ	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospita	li: 1 ☐ Inpat		R/Outpatie	nt 3 DOA	Other:			ne 5 Resi				y)	
ath. : After e fune	ation	1 Natural 5 Pendin 2 Accident investi	g	(Month, D		Injury	М	Work?	s 2 🗆 No				,			
al or Atters after destant of Directors of in by the	Certification:	3 Suicide 6 Could 4 Homicide determ			njury - At ho etc. (Specify		reet, factory, o	ffice		2	8f. Location City or To			or Rur	al Route Number,	
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (Examiner: 0		of examinat		th occurred at nvestigation, in								stated. to the cause(s)	
Withi To th	Ž	29b. Signature and title of certifie						icense n		e.			ate signed (i			
70				ed cause of	f death (Iter	n 23a) (Tune			6111)		Jan	vary	1,2	2012	
(D)		Hardin P	antle, 1	20			,		494	40 Ea	stern A	venu	e, Balt	imo	re, MD, 212	224
Sta Registr		30. Name and address of person Hardin 31. Date filed (Monty An Yoar)	2012	32. Pegist	trar's Signat	ture f.	back									

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2	0	2	0	2	8	
Service.	-		1			

		1- For State Registrar	Certi	ificate of L		i wentan i		2016 eg. No.	0120	
Physici Medical Exam		Decedent's Name (First, Middle,Last) De	nnis Mark Tod	1d			Date of Deat Month January 6,	Day Year	3. Time of Death 1918 hrs	
1		4a. Facility Name (if not institution, give stre		4b.		ocation of Death		4c. County of Death		
F		21521 Indian Bridge Road 5. Social Security Number 6. Sex	7. Age (In yrs. las		California If Under 1 Year	If Under 24Hrs	8 Date of Birt	St. Mary's	nplace (State or	
Funeral Director		217-88-7286 1 k M	_	Months Days	Hours Min	_	/1960 Foreign	North Carolina		
A		Usual Residence of Decedent 10a. State 10b. County		own or Location			03/23	7 1 7 0 0	10d. Inside City Limits	
d how any	_			own or Location	0-146				1 Yes 2 X No	
Maryland 28a-f show d at once.	Director	Maryland St. Mary 10e. Street and Number	7 S	1	Califo Of. Zip Code	ornia	10	Og. Citizen of What Coun	try?	
eath with the Maryland items 23a or 28a-f sho ust be notified at once,		21521 Indian Bridg				619		USA		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? Yes 2 No			anic Origin? (Sp Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,	
after d	by FL	3 Widowed 4 X Divorced If Ye	s, Give Year ates:		**	specify:		Specify: Whit		
2 hours "natur		15. Decedent's Education (Specify only his Elementary/Secondary (0-12)	ghest grade completed) 1 College (1-4 or 5+)			on (Give kind of v DO NOT use reti		16b. Kind of Business/Ir	ndustry	
036 rithin 7 rr than Medical	Completed	12	,		Disable	ed		Disab1	ed	
ID 21215-0036 : should be filed within 77 and Mental Hygiene. ?7 is marked other than natic event, the Medical	Be Co	17. Father's Name (First, Middle, Last)	Todd Cm		18			laiden Surname)		
212 ould be Mentz mark	To B	Edwin Daniel 7 19a. Informant's Name/Relationship (Type,		19b. Mailing A	ddress (Street		E Lee Wi Rural Route Num	LSOII ber, City or Town, State,	Zip Code)	
MD nd 2 sho alth and alth and are 27 is		Cassady Lee Todd/ Da					Road Cal	ifornia, MD		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura injury or other traumatic event, the Medical Exami		1 Burial 2 Cremation 3 R	emoval from State Ma Fr	ematory or other ingley (· I	/9/2012	20c. Location - City or T Leonardto		
altim mit. Pa partmen portant		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	Funer	al Home (e and Address o	of Facility				
	y y	1 1 miles 1 miles	dener	Ma 415	ttingley 90 Fenw	y-Gardir ick Stre	ier Fune et Leon	ral Home, P ardtown, MD		
Physician // // // // // // // // // // // // //		23a. Fart I. Enter the disease, or complication tailure. List only one cause on each line.	e.	o not enter the i	node of dying, s	uch as cardiac o	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death	
Examiner			iple Injuries o (or as a consequence of):						Dodui	
	ē	Sequentially list conditions, b	o (or as a consequence of):							
<u> </u>	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
cecuted 1 and - transit		events resulting in death) Last Due t	o (or as a consequence or).							
760, cate be exe physician a he burial -	Medical		ENDED							
876 rtificate ing phy as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna Live birth	ncy 2 Fetal	death 3	Ectopic pregna	ancy	23d. Date of delivery Month Da	ay Year	
Box 687 death certific the attending performs as the	Physician/	1 Yes 2 No 9 Unknown g	Pregnant at time of death Unknown	h 5 Other	(Specify)					
P.O. By s that the de med by the detached f			ributing to death but not resu	ulting in the unde	erlying cause giv	ven in Part I.		pacco use contribute to the		
ds, P.C requires that been signed rould be deta	ted by		<u> </u>			-	1 Yes	2 No 3 Proba	opsy findings available	
Records, The law require ficate has been si	Completed						autops perform	prior to co ned? death?	mpletion of cause of	
tal Rection: The certificate ector, page		25. Was case referred to medical			26.Place o	of Death (Check	1 Yes 2	No 1 V Yes	2 No	
of Vital og Physician ther this certi	To Be	examiner? 1 Yes 2 No	I Inpatient 2 E	R/Outpatient 3				Residence 6 🗸 Other:	Scene	
on of adding Pl		1 Natural 5 Pending	(Month Day Year)	8b. Time of Injur 1000 hrs	` ``	at Work? es 2 ✔ No		ow injury occurred truck by auto		
Division tal or Attendi rs after deat. al Director led in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	e, farm, street, f	actory, office bui	lding, etc.		treet and Number or Run	al Route Number, City	
District Dis		4 Homicide determined	(Specify) Major Road			1	,	Bridge Road, California		
Division of Vital Records, P.O. Box 68760, To the Hostital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely illed in by the funeral director, page 2 should be detached for use as the burial - transi	edical	one) 2 Medical Examiner: On the	to the best of my knowledge, ne basis of examination and							
F E E	Ě	29b. Signature and title of certifier	manner stated.		29c. License			29d. Date signed (Mont	h, Day,Year)	
		Paniett outhers	(m)	2-1	O.C.M	.E.		January 7, 2012		
3) pm	ŀ	30. Name and address of person who compl Pamela E. Southall, MD Ass	eted cause of death (Item 23 sistant Medical Exami	*	/. Baltimore	Street, Baltii	more, MD 21	223		
	ate	31. Date filed (Month, Day Year) JAN 1 1 2012	37 Registrar's Signature	park	1					
- regio	المنت	A =	/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Daniela Beatriz Machado Umaña ам 2:03 January 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 0 O Yrs. 0 4 Dec. 31, 2011 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits

10f. Zip Code

16a. Decedent's Usual Occupation

Never Worked

20740

(Give kind of work done during most of working life. DO NOT use retired)

work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D72315

#200

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 🗌 No

Hyattsville, MD 20783

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 🛱 Yes 2 🗆 No Specify: Salvadorean

1 Yes 2 X No

Interval Between Onset and Death

Dav

28f. Location (Street and Number or Rural Route Number

29d. Date signed (Month, Day, Year)

Jan. 1, 2012

City or Town, State)

10g. Citizen of What Country?

Specify:

None

18. Mother's Name (First, Middle, Maiden Surname)

Lorena Beatriz Umana

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16b. Kind of Business/Industry

14. Race - American Indian,

White

Black, White, etc

USA

Funeral Director 28a-f show notified at Director ò er than "natural", or items 23a or the Medical Examiner must be Funeral þ Maryland 21215-0036 Completed al Hygiene. Be 2

Physician/

Medical

<u>Examiner</u>

MD

11. Marital Status

10e. Street and Number

P.G.

15. Decedent's Education (Specify only highest grade completed)

Pastor Fabricio Machado

19a. Informant's Name/Relationship (Type, Print)

5110 Odessa Road

1 X Never Married 2 Married

3 Wildowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

other traumatic event, should be file and Mental H f Health a permit. Page 1 a
Department of H
Important: If ite
any injury or ott

Baltimore. Di-Cian cal Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial as signed by the at d be detached for page 2 funeral the

68760

Box

Division of Vital Records, P.O.

Examine Physician/Medical <u>م</u> Completed Be မ Certificate: filled in by Medical 29a. Certifier

1X Natural

Accident

3 [

Padmapriya Sundaram, MD

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Suicide

4 🗌 Homicide

(Check

5 Pending

Investigation

6 Could not be

Pastor Fabricio Machado/Father 5110 Odessa Road, College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 $\[\]$ Burial 2 $\[\]$ Cremation 3 $\[\]$ Removal from State Jan. George Washington Cemetery 2012 4 Donation 5 Other (Specify) Adelphi, Maryland nature of ineral Service Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preterm Labor disease or condition resulting in death) Due to (or as a consequence of) Incompetent Cervix, Maternal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Extreme Prematurity Due to (or as a consequence of): resulting in death) Last Remote from Viability IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 🛣 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 🗶 No Other: 1 Yes 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred

College Park

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 🛣 No

College (1-4 or 5+)

If Yes, Give Year or Dates

DHMH 17 Rev 06-2011

State Registrar injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ause of death (Item 23a) (Type, Print) #2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Physician/ Se 2012 6:05A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Health mher 6. Sex Talbot Care-The Pines Genesis Easton If Under 24 Hrs. 8. Date of Birth If Under 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 12 F Months Days Hours Min (Month, Day, Year) Country) Director Mar4 28a-f show 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Funeral Director 1 Pyes 2 No Dorchester and Mental Hygiene. is marked other than "natural", or items 23a or 10e. Street and Number 10g. Citizen of What Country? ace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important if firem 27 is marked other any injury or other 1 δ 1 Never Married 2 Married Louise Williams Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) hild Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland orrena 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 2012 4 Donation 5 Other (Specify) TUYlock 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral 23a. Part y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD Physician/ Chronic monard disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Certificate: To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death 5 Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 1 Natural 28c. Injury at work? 28d. Describe how injury occurred 5 \square Pending 1 Yes 2 Accident
3 Sulcide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a, Certifler Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After completed filled in by the funer.

> State Registrar

(Check only one)

30. Name and add

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 06 201

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

-201a

12-00331 James C Wilmot Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lames C Wilmo	τ	1- For Stata Registrar	State of Maryla		artment of ertificate of		d Mental I	_	Reg. No. 201	2 0128
Physici Medical Exami		Decedent's Name (First, Mid JAMES C.	ddie,Last) WILMOT					2. Date of Dea	Day Year	3. Time of Death 1823 hrs
*		4a. Facility Name (if not institu		mber)	1	4b. City, Town, or	Location of Dea	January 1	4c. County of Deat	
Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday						Bethesda	If Under 24H	rs 8 Date of R	Montgomery irth(MM/DD/YYYY) 9. Bi	rthnlace /State or
Director		213-78-4058	1 X M 2 F	54		Months Days		in	Forei	
u		Usual Residence of Decedent 10e. State 10b. Count	у	10c. City	, Town or Locati	on				10d. Inside City Limits
	5	Maryland Mont	gomery	Pot	omac					1 Yes 2 X No
Maryla r 28a-f ed at o	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What Cou	•
with the Maryland us 23a or 28a-f sho pe motified at once		12571 Ansin (edent Ever in U	IS 13 Wa	208 s Decedent of His		Specify Yes or No	United Sta	rican Indian, Black,
5 72 hours after death with the Maryland 72 "natural", or items 23a or 28a-f sho	Funeral	1 Never Married 2 X				es, specify Cuban			White, etc.	
irs after ural",	þ	3 Widowed 4 C	or Dates:			Yes 2 X No		work done	Specify: W II	ite
5 72 hou in "nat	Completed	Elementary/Secondary (0-12			during m	ost of working life.				
5-003 ed within Tygiene. other the	ошо	17. Father's Name (First, Middl	4 (a Last)		Archi		19 Mother's Nam	o /First Middle	Architect	ure
三元 海中 るべし	Be	John C. Wiln						Beesle		
e, MD 2121 I and 2 should be for Health and Mental item 27 is market	7	19a. Informant's Name/Relation Caron M. Wiln							mber, City or Town, State mac, MD 208.	
imore, MD 2 Pages 1 and 2 shoulment of Health and hant: If item 27 is no other traumatic		20a. Method of Disposition 1 Burial 2 X Crematic	on 3 Removal fro		Place of Disposi crematory or oth	tion (Name of cen	netery, Ja	Date 17,	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		4 Donation 5 Other	Specify:			tan Crem		2012	Alexandri	a, VA
Bal permi Depar Impo		21. Signature of Funeral Service		M01116)					eral Home ithersburg,	MD 20877
Physician Wedical		23a. Part I. Enter the disease, of failure. List only one cause	e on each line.						est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final diseas or condition resulting in death)	a. Atheros Due to (or as a			ovascu1a	r Disea	se		Death
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as e	consequence of	A)-					
	miner	cause. Enter Underlying Cause (Disease or injury that initiated C								
r and ransit	I Exa	events resulting in death) Last	d	consequence o	п):					
O, e be execut ysician and burial - trar	edical	X UNPENDED	AMENDED	23a,27,	per me,	g924 2-1	3-12 sm			
OX 6876 eath certificate attending phy for use as the b	Z Z	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes, o	utcome of preg th		al death 3	Ectopic pregn	ancy	23d. Date of deliver	y Day Year
Box (e death ce the attence ed for use	hysici		nknown 9 Unkno	int at time of de wn	eath 5 Oth	er (Specify)				
that the detached	by Ph	Part II. Other significant cond	itions contributing to	death but not re	esulting in the ur	nderlying cause gi	ven in Part I.		obacco use contribute to	
ords, P.C. w requires that s been signed I should be deta								1 Yes	s 2 No 3 Prot	topsy findings available
ecor he law r te has b	Completed				<u> </u>			autop perfor 1 ✔ Yes	osy prior to o rmed? death?	completion of cause of
tal Rectan: The certificate ector, page	Be C	25. Was case referred to medic examiner?	-				of Death (Check	only one)	2 No 1 Ye	es 2 No
of Vit	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 In		ER/Outpatient 28b. Time of In		Other Nursi	 -	Residence 6 Other	:
ion of tending Pl eath. or: After the funera	tio	1 X Natural 5 Per	(Month,	Day,Year)	200. 71110 0. 111	·	es 2 No	200. Describe i	now injury occurred	
ivision of the district of the by	Certification	3 Suicide 6 Cou	lid not be	of Injury - At ho	ome, farm, street	, factory, office bu	ilding, etc.	28f. Location (S or Town, S	Street and Number or Ru state)	ral Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funceral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - mansi		4 Homicide	(0,000)	of my knowledg	ge, death occurr	ed at the time, dat	e and place, and	due to the caus	se(s) and manner as state	ed.
thin the mple	Medical	one) 2 Madical Ex	aminer:On the basis of and manner sta	examination ar		on, in my opinion,	death occurred		and place, and due to th	e cause(s)
3-PEND	2	29b. Signature and title of certif.	v S			29c. License O.C.M			29d. Date signed (Mo.	
	}	30. Name and address of perso	n who completed cause	of death (Item	23a)					
	160		ant Medical Exam				more, MD 2	1223		
Sta Registi	rar	31. Date filed (Month, Day, Year,	012 Jenes	istrar's Signatu	re back					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 01289 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 201^{Year} 1 2:30 pM Linda Kaye Winternitz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15604 Yellowhorn Ct. Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 □XF 06-06-1947 Days Hours Country) **Director** WV 235-74-0404 Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No Rockville MD Montgomery 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 15604 Yellowhorn Ct. 20853 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lona Elizabeth Bolyard William Howard Goodwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel P. Winternitz - Husband 15604 Yellowhorn Ct., Rockville, Maryland 20853 item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 1-4-2012 Falls Church, VA National Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Danzansky-Goldberg any ir 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part T. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Colon Cancer vears Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed Dause (Disease or impury that initiated events Due to (or as a consequence of): resulting in death) Last burial Physician/Medical Box 68760 attending p for use as t IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 1 Yes 2 X Yes 2 No g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 22 No prior to completion of cause of death? s certificate has lirector, page 2 2 🗶 No Yes Be (25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? Hospital 2 **X** No Other: 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 4 Nursing Home Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural (Month, Day, Year) 5 Pending injury within 24 hours after death.

To the Funeral Director: A 1 Yes 2 No Accident Investigation M Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pleted f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 10 toseste M. Ita D32407 January 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

MD

Joseph M. Hagerty,

JAN 03

31. Date filed (Month, Day, Year)

- 9707 Medical Center Drive, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Francis Wilson, Jr. 7:27 AM Medical Òί 001 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbur oastal Hospice Dicomico Social Security Number If Under 1 Year If Under 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 ፟ M 2 ☐ F Months (Month, Day, Hours **Director** 213-40-1217 67 944 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2X No MD Worcester Berlin 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 26 Capetown Rd. 21811 USA "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Xyes 2 No Black, White, etc. 1 Never Married 2 Narried þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Completed white Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Trucking/ Elementary/Seconday (0-12) College (1-4 or 5+) Regional Labor Relations Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Francis Wilson, Doris Marie Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Della Wilson / wife 26 Capetown Rd., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 D Other (Specify) Evergreen Cem. 1/6/2012 Berlin, MD 21. Signature of June 1 Service Licenses 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the liseast, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or lach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ALIGNANT COLON CANCRA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to or as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Other (specify) Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence Other (Specify) HOSP1 \square Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Ci Hulym

31. Date filed (Month, Day, Year)

WAR

JAN 05 2012

Registrar

1733

0

32 Registrar's Signature

130-0

Please Type or Print in Black Indelible Jnk. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year Month Physician/ 2012 Ethel Colee Hart Wilson January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Age (In vrs. last birthday) 01/ 1 🗆 M 2 😾 F Days Hours 08 Florida 194<u>1</u> **Director** 71 266-56-6390 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director or 28a-f sl e notified 1 🗌 Yes 2 🙀 No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 41560 Burnt Mill Drive 20636 United States items 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 9 1 Never Married 2 Married þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates er than "natur , the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Teacher Education permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, til once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joe Hart Ethel Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Asbury Wilson-Husband 41560 Burnt Mill Drive, Hollywood, Maryland 20636 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/13/2012 Brinsfield-Echols Charlotte Hall, Maryland Kathleen A. Santivasci-M00872 22. Name and Address of Facility Brinsfield Funeral Home, PA 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician! Scizures disease or condition resulting in death) Medical Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events requires that the death certificate be executed Osteoporosi and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Synlop Division of Vital Records, P.O. Box 68760 the attending p IE FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by None 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy page Yes 2 N Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 은 Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No s after death. 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D68923 VX as March 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24035 Three Notch Road, Hollywood, MD 20636 Vijayal Guduri M.DJAN 13 2012 Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles Michael Wheeler, Sr. 2012 11:50 AM Medical January 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 46352 Columbus Drive # 1405 Lexington Park St. Mary's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/16/1956 **Funeral** '. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗽 M 2 🗀 F Months Days Hours Min Yrs. **Director** 55 212-66-7227 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. Count should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No St. Mary's Lexington Park Maryland 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Completed by Funeral 46352 Columbus Drive #1405 20653 USA "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Radar Systems Engineer Defense Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Martha Elaine Wood George Bernard Wheeler and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Department of Health Important: If item 27 Jonathan Wheeler/ Son 935 Chart Court Lusby, MD 20657 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) any injury Holy Face Catholic 01/13/2012 Great Mills, Maryland permit. 21. Signature of Funeral Service Di 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home,
41590 Fenwick Street Leonardtown, MD 20650 Jaro 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and eath Immediate Cause (Final Ph, sician/ Metastate disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant Unknown Pregnant at time of death Month Dav Year the 1 ☐ Yes 2 ☐ Unknown q has been signed by e 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 N 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 은 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No injury 5 Pending

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 **Director:** After this certificated in by the funeral director, pag

Maryland 21215-0036

Baltimore,

within 24 hours after c

To the Funeral Direct

completed filled in by Medical

Accident Suicide

State

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5668 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print abran

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year)

Investigation

Could not be

determined

6

Registrar

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

AND RECYS

9

5

AYMO

S

KNOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#2, perPHYS, G923, 1/23/2012 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1-19-Month Physician/ Thomas Askew Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Good Samaritan Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Date of bill. (Month, Day, Y **Funeral** 1 QM 2 □ F Days Hours Min 217-70-2479 Yrs Director 54 956 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Examiner must be notified MD Baltimore 1X Yes 2 No Street and Number 7054 McClean Blvd or 10g. Citizen of What Country? 10f. Zip Code 23a 21234 USA items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 'natural", or þ 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 1 Never Married 2 Married 1 Yes 2X No Specify SpB#Yack 3 Widowed 4 Divorced Completed and Mental Hygiene.
is marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bierman TruckingCo Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 12th Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Thomas Woodard Larnie Mae Askew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta M. Birchett (sister) 3509 Elmora Ave Balto, Md. 21213 mportant; If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 0 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Crematory 26,201 injury (Mount Balto, Md. 4 Donation 5 Other (Specify) Green e of pansyal Sovice Licens, e 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home
1412 F. Preston St. Balto, Md. 23a. Part 1. Erner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23b. Was decedent pregpant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No detached for Month Day Year 1 ☐ Yes 2 E 9 ☐ Unknown the Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medic Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ٩ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier o completed cause of death (Item 23a) (Type, Print) RUD COURT · sue Day. 31. Date fi 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2012 TANGELIA DENISE WASHINGTON BUNDY 2:00 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 3525 Terrace Drive Apt. Suitland Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🗌 M 2 🕱 F Days $J\mathbf{u}^{(Month, Day)}$ Hours Country) 577-92-2549 Director DC 50 Usual Residence of Decedent 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Suitland Prince Georges 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? by Funeral 23a USA 20746 3525 Terrace Dr. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Armed Forces?
1 ☐ Yes 2 ☒ No 10 Black White etc. 1 Never Married 2 Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes Give "natural", Specify Completed 3 Widowed 4 Divorced Year or Dates Black h and Mental Hygiene. 7 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PG County Schools Cook 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Gloria Jean Armwood Homer Gates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 3525 Terrace Dr. #A Suitland, MD 20746 Charkellia Hawkins - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I cemetery, crematory or other place) ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1-19-2012 Alexandria, Va 21. Signature of Funeral Service Licenses All Marshall March Funeral Home of Maryland Estavine Suitlnad, MD 20746 4308 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 18 Montens Physician/ Cervical Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical 09/89 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available

prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 **Division of Vital** Be 25. Was case referred to nedical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of te Hospital or Attending P n 24 hours after death. te Funeral Director, After t Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work? Accident 2 🗆 No Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Henry Babb January 2012 11:32 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Gilchrist Hospice If Unde Social Security Number 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months Hours 416-48-8520 Director 1 🗶 M 2 🗆 F Yrs. 78 March 4, 1933 Georgia Usual Residence of Decede 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗌 Yes 2 🗶 No Virginia Chesterfield Mid1othian 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 2711 Leafield Drive 23113 U.S.A. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 K Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: 3 X Widowed 4 □ Divorced Completed White is marked other than "natu aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Sears and Roebuck Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Zack Thomas Babb Eva Elizabeth Camp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Stephanie Marinelli 2904 Excelsior Springs Court Ellicott City, Maryland 21042 (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 K Burial 2 Cremation 3 Removal from State Greenwood Memorial Gardens 1-26-2012 4 ☐ Donation 5 ☐ Other (Specify) Richmond, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) DIMPES Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Erter Unterlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2/No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 2 Accider 5 Pending Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14 2012 Physician/ BARTON R. JOSEPH JANUARY 12:10 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15001 ROLLING MEADOWS RD. UPPER MARLBORO PRINCE GEORGE'S Social Security Number **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Days Months Hours NOV . 25 SOUTH CAROLINA 1933 Director 250-48-4117 78 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10g. Citizen of What Country? Funeral 15001 ROLLING MEADOWS ROAD 20772 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ N♠RMY If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 2 NARMY Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) 4YRS SYSTEM ENGINEER FED. GOVERNMENT Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 1 and 2 should be filed f Health and Mental H item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) ည JOE BRAWLEY BARTON ROSA RYAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 BARTON/WIFE 15001 ROLLING MEADOWS RD. UPPER MARLBORO, MARYLAND LILA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of H Date 1X Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) VETERANS CEMETERY 1/24/2012 CHELTENHAM MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility $J.\ B.\ JENKINS\ FUNERAL\ HOME, INC.$ 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. English the display shock, or heart failure. Immediate Curre (Final disease or condition resulting in death) as , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Interval Between Onset and Death Physician/ MYELODYSPLASTIC SYNDROME Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical phy: the as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 2 🔀 No 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 2 XNo 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending injury s after death.

I Director: Aff 1 Yes 2 No Accident
Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check

68760

of Vital

Division

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Jocelyne

EAST UNIVERSITY PARKWAY BALTIMORE, MARYLAND 21218 32. Registrar's Signature

201

Kouatchou, MD

and address of person who completed cause of death (Item 23a) (Type, Print)

JOCELYNE KOUATCHOU M.D.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

163748

29d. Date signed (Month, Day, Year)

JANUARY 19, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. state of Marvian 1970 charanters of 148 at 148 and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Annette C. Blank 4:10 A TAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITH OF BALTIMURE BALTIMORK CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 X X June 1, Year 925 579-30-4121 86 York Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f shor with the Maryland Director event, the Medical Examiner must be notified XXIES 2 No Baltimore Baltimore Pikesville MD or 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a U.S.A. 7218 Park Heights Ave. 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces?

1 Yes XXN

If Yes, Give
Year or Dates. Black, White, etc. or þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes XX No Specify: White "natural", 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Library Librarian Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o Frances Freifield Solomon Chotin permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any nijury or other traumatic once. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 96 Mt. Rainier, MD 20712 Emily C. Blank / Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State cametary, camatori or other place)
Crematory & Chapel 1/24/12 1 Burial XXCremation 3 Removal from State Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Faciliteckhardt Funeral Chapel P.A. 21. Signature of Funer I Service Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 ne 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final Privsician/ Medical resulting in death) TRACT INFECTION Examiner DAYS URINARY Sequentially list conditions Examiner If any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Tonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy 1 Yes 2 10 certificate Yes 2 4 25. Was case referred to edical examiner?

1 Yes 2 No 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 atural work? 5 Pending Accident Investigation Director: the Funeral Directory filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hc

To the Fune

completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature/and title of certifier 29d. Date signed (Month, Day, Year) D006902 JAN 21,2012 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

RCAWK

1-2

W

DHMH 17 Rev 7/2009

M.D.

PrICE

31. Date filed (Month, Day, Year)

JAN 2 3 2012

STWAF

32. Registrar's Signature

HUSPITAL OF BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Brucus 2017 3:28 CM 2 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ER NESTMINST If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In <u>y</u>rs. last birthday) Country) 8357 1 ☐ M 2**X** F Hours 01 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 1 🗆 Yes 2 🌠 No CARROLI FINKSBURG 10e. Street and Number 10g. Citizen of What Country? SYKESVILLE ROAW 2104 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 No 1 Never Married 2 Married 1 Yes : 1 ☐ Yes 2 🔊 No Specify. WHITE 3 Widowed 4 ☐ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) STANDARD OIL VATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname))NKNOUL FANNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TNKSBURGMO 21048 STHER DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WINGIELD, MO 1-21-2012 22. Name and Address of Facility \ NZmbw | EH & mov 6. Signature of Funeral Service Licensee YKERVILLERO ELDERUBURGMO 21784 23a. Fart VE withe disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse ce of) V eux Due to for as a consequence of Due to (or as a consequence of)

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran

Physician/

Medical

10a. State

Director

Completed by Funeral

Be

ည

Examiner

Physician/Medical

۾

Completed

Be

မ

Certificate:

Medical

IF FEMALE

Examiner

Funeral

Director

, or items 23a or 28a-f show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months?

Was case referred to medical

29b. Signature and title of certific

Yes 2 No 1 Yes 2 9 Unknown

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant a 9 Unknown Pregnant at time of death 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Dove Hou

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 No 3 Probably 4 Unknown 24a. Was an autopsy performed

24b. Were autopsy findings available prior to completion of cause of death?

2-1 N Yes 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	eatient 3 DOA Other: 4 Nursing	Home 5 Residence 6 Other
. Manner of Death	28a. Date of injury 28b. Tim		28d. Describe how injury occurred
1 Natural 5 Pending	(Month, Day, Year) inju	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
2 Accident Shyestigatic	, 1	M 1 Yes 2 No	

3 Suicide 4 Homicide 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

10034278

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) washing ct, clarksville MD

31. Date filed (Month, Day, Year) 32. Registrar's JAN 2 3 2012

State Registrar

within 24 hours after death

To the Funeral Director:
completed filled in by the

in by the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar		epartment of I Certificate of L		/lental Hy	giene Reg. No. 20	12	01300
ı	Physicia	ın/	1. Decedent's Name (First, Middle, I	.ast)	W. A.			2. Date of De	eath	Year	3. Time of Death
	Medic	al	JAY M 4a. Facility Name (if not institution, g		ENTHAL	4h City Tours o	r Location of Death	JANUA		O12	1:25 P M
	Examir	er	GILCHRIST HOS	,		TOWSO			4c. County	or Death LTIMO	RE
	Funeral Director		5. Social Security Number 219-30-7707	Sex 7. Age (II	n yrs. last birthd 8 Yn	ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 01/09/	th		lace (State or Foreign
	and show lat	or	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town o	r Location				1	0d. Inside City Limits
	Maryli 28a-f otifiec	Funeral Director	MD BALT	IMORE	BAL	TIMORE					1 🗆 Yes 2 🔀 No
	th the	al D	10e. Street and Number			10f. Zip Code			10g. Citizen of V		try?
	ath wi	nner	1 GRISTMILL CO	URT, #304	rintLS	212		ecify Yes or No-	USA 14 Page	A e - Americ	on Indian
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		Rican, etc.)	Blac Specify:	k, White, e	
5-0	2 hour	plet	15. Decedent's (Specify only highest			ecedent's Usual Occup		ing .	16b. Kind of Bu	usiness Inc	lustry
121	ithin 7	Com	Elementary/Seconday (0-12)	College (1-4 or 5+) 5+	lif	e. DO NOT use retired) TIFIED PUB	ATTORN	ĔY /	ACCO	INTIN	G
DQ 2	illed wall Hygiland Hygiland	Be	17. Father's Name (First, Middle, Las		, obi	TITIED TOD	18. Mother's Nam				0
ylaı	Menta Menta narked natic e	잍	HENRY		MENTHAL		LILLIE]	FAMIL	ANT
Mar	2 shouth and the and traum		19a. Informant's Name/Relationship			lailing Address (Street					
	f Health item 27 other tra		MYRNA BLUMENTH 20a. Method of Disposition		20b. Place of D	GRISTMILL isposition (Name of		Date BAI	20c. Location -		21208 wn, State
<u>=</u>	Page nent o ant: If ury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ARLIN AMIN	Crematory or other place GTON CHIZU CEMETERY	Ö 01/2	0/2012	BALT	IMORE	, MD
Baltimore,	permit. Departi Import any inji		ROS., LE, M	INC. D 21208							
	Physician/ Medical Examiner	er	23a. Part 7. Enter the disease, or or shock, or heart fallure. List onl immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	one cause on each line.	ATE Consequence of):	enter the mode of dyin					Approximate Interval Between onset and Death
160	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as a co							
. Box 68	ne death certific y the attending I ched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at tir 9 Unknown	Fetal death	3	у		23d. Dai Mo	te of delive	ry Day Year
ls, P.O.	uires that the des n signed by the a Id be detached f	by	Part II. Other significant conditions	contributing to death but r	not resulting in t	he underlying cause giv	ven in Part I.				e cause of death? eably 4 □ Unknown
Record	sician: The law require: certificate has been signector, page 2 should b	Completed							psy ormed?		sy findings available npletion of cause of
<u> </u>	cian: ertifica ector, p	Be (25. Was case referred to medical examiner?	Hospital:		26. Pl	ace of Death (Check		2 2 110		
Division of Vital Records,	nding Physician: T tth. : After this certifica : funeral director, p	cate: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	er <i>(Specify)</i> ed	HOSPILL						
Divisio	tal or Attendi rs after death al Director: A led in by the fi	al Certificate:	3 Suicide 6 Could no 4 Homicide determine	be 28e Place of Injury	- At home, farm Specify)	street, factory, office		28f. Location (3 City or Tox	Street and Number vn, State)	er or Rural	Route Number,
	To the Hospital of within 24 hours at To the Funeral D completed filled it	Medical	(Check 2 Medical Exa only one) 3 Certifying N	nysician: To the best of my miner: On the basis of exan urse Practioner: To the bes	nination and/or in	vestigation, in my opinio ge, death occurred at th	on, death occurred at e time, date and place	the time, date a	and place, and due te cause(s) and ma	to the cau	se(s) and manner stated. ited.
0	11/10		29b. Signature and title of certifier	4.40	nn	29c. License	1636L	2	JANVI		10
	10 1.		MICHAEL S.	completed cause of deat	0670	e, Print) November	Chras	25 STVA	er BAC	Time	[8,29Z meM02120
	Stat Registra	e ar	31. Date filed (Month, Day, Year) JAN 2 3 2012	32. Registrar's	Signature	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death 2012 Year Physician/ Jean Coleman 2010 January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Age (In vrs. last birthday) 8. Date of Birth 1 🗆 M 2 💢 Hours Min. Director 246-54-5690 Usual Residence of Decedent show ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 Yes 2 No MD. Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7933 Westmoreland Avenue Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: African-American Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) iould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Public Schools <u>Teacher</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o ပ္ Floyd Brothers Leolia Bernard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Maurice W. Coleman /Husband 7933 Westmoreland Avenue, Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important; If it any injury or o once. Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 1-24-2012 Parkwood Cemeterv Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 🗌 Yes 2 🔲 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident М Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Cettifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ture and title of certifie 29b. Signa 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shahoeu 6701 State Registrar

DHMH 17 Rev 7/2009

12-00481 John Metcalfe Curran

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 01302

		1- For State Registrar	Certifica	ate of Deati	7	F	Reg. No.	45					
Physic			ath	3. Time of Death									
Medical Exam	ııne	JOHN PROCESSING CULTS				Month January 1		1322 hrs					
		4a. Facility Name (if not institution, give street and number) 85 Carroll View Avenue			own, or Location of ninster	Death	4c. County of Dea Carroll	th					
Funera		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birth	-	r 1 Year If Under		irth (MM/DD/YYYY) 9. B	irthplace (State or					
Directo		216-88-1954 1XM 2F	49	Yrs. Months	Days Hours	Min. Sept.	19,1962 Fore	ountry)Maryland					
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town of	or Location	_			10d. Inside City Limits					
.	L	Maryland Carroll		Woct	ninster			1 X Yes 2 No					
nyland Sa-f show	용	10e. Street and Number		10f. Zip		11	10g. Citizen of What Co						
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. T's in marked other than "nastural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	Director	85 Carroll View Ave.			2115		U.S.A.						
h with ms 23 be ng	Funeral	11. Marital Status 12. Was Decedent			t of Hispanic Origin	n? (Specify Yes or No)- 14. Race - Ame	rican Indian, Black,					
r deati or ite	듄	1 Yes 2	X No	if Yes, specify	Cuban, Mexican, I	Puerto Rican, etc.)	White, etc.						
s afte ral",	ğ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade com			X No specify:		ороску.	hite —————					
2 hour	te d	Elementary/Secondary (0-12) College (1-4 or 5			occupation (Give ki ing life. DO NOT u		16b. Kind of Business	•					
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exami	Completed	12	'	stocke	r		distribut	ook					
15-003 illed withi Hygiene. d other th	ြင္ပ	17. Father's Name (First, Middle, Last)				Name (First, Middle,		ion co.					
21215-0036 uld be filed within 7 Mental Hygiene, marked other than c event, the Medica	Be	William John Curran Jr.				Florence M	etcalfe						
AD 21 2 should 1 and Me 27 is ma	ြို	19a. Informant's Name/Relationship (Type, Print)		. Mailing Address	(Street and Numb	er or Rural Route Nur	nber, City or Town, Stat	e, Zip Code)					
e, MD and 2 sho Health and item 27 is traumati		William J. Curran III/broth 20a Method of Disposition		30 E. Gr			ster, MD 2						
S 1 5 1 5		1 Burial 2 X Cremation 3 Removal from Sta	te 20b. Place of cremato	Disposition (Nam ry or other place)	of cemetery,	Date	20c. Location - City o	r Town, State					
Limi Pag ment tant:		4 Donation 5 Other Specify:	AllCou	inty Crem	ation	1/19/2012	Sykesvill	le, MD					
Baltimore permit. Pages 1 a Department of He Important: If it injury or other t		2) Spnature of Funeral Service Licensee		22. Name and A	ddress of Facility	Hartzler F	uneral Home)					
Physician		23a. Part I. Enter the disease, or complications that caused to	he death. Do not	1 P.O. Bo	$\times 249$ 1	New Windso	r. MD 21776	Approximate Interval					
/Medical		failure. List only one cause on each line.											
Examiner		Immediate Cause (Final disease or condition resulting in death) a Cardiomeg						Death					
		Sequentially list conditions, b											
	Examiner	if any, leading to immediate Due to (or as a consect cause. Enter Underlying Cause	quence of):										
	хаш	(Classes or injury that initiated events resulting in death) Last Due to (or as a consecutive consecution)	quence of):										
760, icate be executed physician and the burial - transit		d											
), be exision urial	/Medical	X UNPENDED AMENDED 23a	,pt.II,2	27, per m	e,g925 3-	15-12 sm							
760, ficate be g physic t the bur		IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the	of pregnancy				23d. Date of deliver	у					
Box 68's death certification of for use as	ciar	past 12 months?	2 [ime of death 5	Fetal death Other (Special	3Ectopic p	regnancy	Month	Day Year					
Boy re death the att red for	Physician	1 Yes 2 No 9 Unknown 9 Unknown											
ires that the signed by I be detached	by P	Part II. Other significant conditions contributing to death					bacco use contribute to						
S, P wires t n sign ld be		Focal acute bronchopneumo	nia;Chro	onic Alco	holism;	1 Yes	2 No 3 Pro	bably 4 🗹 Unknown					
Records, P.O. The law requires that the ficate has been signed by ragge 2 should be detact.	Completed	Diabetes Mellitus				24a. Was a autop		utopsy findings available completion of cause of					
Rec The la	ĕ					perfor 1 ✓ Yes	med? death? 2 No 1 ✓ Y	es 2 No					
tal Recion: The certificate	Be	25. Was case referred to medical examiner?		26	Place of Death (C								
Physical direction	P	1 ✓ Yes 2 No		patient 3 DO		lursing Home 5	Residence 6 🗸 Othe	r: Scene					
Division of Vital tall or Attending Physician is after death. To Director: After this certical in by the funeral director.	<u> </u>	27. Manner of Death 28a. Date of Injury (Month, Day,Yea	/ 28b. Tir ir)		c. Injury at Work? 1 Yes 2 N		now injury occurred						
Signal Atter	Cat	2 Accident Investigation 28e Place of Injury	ny - At home for	n, street, factory, o			211	15 11 1 6					
Div pital or cours after filled in	Certification:	3 Suicide 6 Could not be determined (Specify)	ry - 74 Home, fam	n, succe, ractory, t	ince building, etc.	or Town, S		ıral Route Number, City					
Hospi 24 hou Funer tely fil	<u>a</u>	29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death	n occurred at the ti	me, date and place	and due to the cause	e(s) and manner as stat	ed.					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	edical	one) 2 Wedical Examiner: On the basis of exami and manner stated.	nation and/or inv	estigation, in my o	pinion, death occur	red at the time, date	and place, and due to th	e cause(s)					
E S E S	M	29b. Signature and title of certifier		29c.	icense number		29d. Date signed (Mo	nth, Day,Year)					
6		high, s			D.C.M.E.		January 18, 201	2					
9		30. Name and address of person who completed cause of dea			D. III	0.400							
/	7,5	Ling Li, MD Assistant Medical Examiner			Baltimore, MI	21223							
Regis	ate trar	31. Date filed (Month, Day Year) 32. Registrar's	gnature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 19/2012 12:30PM Physician/ Margaret Rachel Campbell Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Westminster Golden Living Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours Min. Country) 9 7 1 7 19 2 1 MD 90 Director 215-14-8072 Usual Residence of Decedent 28a-f shov 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at **Funeral Director** 1 Yes XX No MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1234 Washington Rd. 21157 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Child Care Clerk, Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret Helen Black Howard Esworthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3604 Lineboro Rd., Manchester, MD 21102 Brenda Nunn/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State ò permit. Page Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2012 Frederick, MD Grove Cem. Locust 21. Signature of Funeral Service Lice see ²² Name and Address of Facility Funeral Home & Crematory, P.A. Liberty Rd., Winfield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) war. Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 2 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Aursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer iniury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day)

and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CLARK VANUARY AGNES 78 2012 10:10 PM Medical Facility Name (if not institution, give street and number) Town, or Location of Death Examiner ikesville Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Date of Birth **Funeral** Age (In yrs. last birthday) Month, 28 212-22-7228 88 1 M 2 N Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Nes 2 No More 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Inday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 Print) her Department of Health Important: If item 27 any injury or other th 20b. Place of Disposition (Na Method of Disposition 20c. Location - City or Town, State Date 1 Warrial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ark Signature of Funeral Service License 23a. Part 1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ SMGNITA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ASCULAR 6 YEARS BERZYGI Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month has been signed by the age 2 should be detached 1 L Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DinBETES MEllitus, Type-11 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? PRITTNSIOM 24a. Was an autopsy page After this certificate 2 🗌 No 1 Yes Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) 2 1 No Hospital: Other: မ 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) iniury Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No 2 Accident Investigation the 1 within 24 hours after dea

To the Funeral Director

completed filled in by th 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) d title of certifier 29b. Signature ar R088852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 2835 mins

AUENUE #203 Barinar Mary/AND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 17 per FH G923 1/23/12 dk.
State of Maryland Department of Health and Mental Hygiene
AMEND TTEM#19b, per FH, G923 1/25/2012, WS

Certificate of Death

Reg. No. 2012 1 - State Registrar 305 1. Decede 2. Date of Death 3. Time of Death Day Year Month **Physician** arrol 1245 4 M ndrea 18 2012 JANUARY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ST- Lenus + Social Security Number BALT MORE MID If Under 1 Year If Under 24 Hrs. HOSPITAL 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 215.76-3836 1 M 2 □ F Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director DOG lawn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 □Yes 2 ☑No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Oerator other's Name (First, Middle, Maider Puther's Name (First, Middle, Last) Be 0 George A. Carroll ved 2 19b. Mailing Address (Street and Number or Fu al Route Number, City or Town, State, Zip Code) (Type. Print) Walden ood lawn 16 MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligens 23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PROSTATE Immediate Cause (Final CANCER pars. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unerships Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of): nding physician Physician/Medical the use as f IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Tyes 2 No 3 Probably 4 D Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No this certificate 1 □Yes 2 No 1 ∏Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient ည 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending within 24 hours at er death. 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier HNUARY 18,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 21229 CHINTAN SATTMORE, MI) SHIEL South CHION 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

P.O.

of Vital Records.

Division

A725 LL

				Pleas	e Type o							•		_	ible.		
			For State Registrar		State	of Maryla		epariii Certifica				ientai ny	Reg. N	0.0	10	0,130	5
			Decedent's Nam	ne (First, Middle, L	ast)			30711110	410 01	Journ		2. Date of D	eath	C. U		3. Time of Death	Ų
	/sicia /ledic		AllEN	1 COOK	C, JR							Tanua	ry ?	8 2	Year O\1	12:08 pm	1
Ex	amin	er	4a. Facility Name (if			mber)			ity, Town, o			,	7 4	c. County	of Death		
Fur	eral		5. Social Security N	lumber 6.	sex sex	7. Age (In yrs.	last birtho	day) If Ur	der 1 Year	If Unde	er 24 Hrs.	8. Date of Bi			9. Birth	place (State or Foreigr	n
	ctor		216-52-	7010	1 X M 2□ F	(61 Y	rs. Mont	hs Days	Hours	Min.	(Month, D	ay, Year) 3 - 1	950	Cour	SC Stry)	
pu Mod	at	ř	Usual Residence of 10a. State	f Decedent 10b. County		10c. C	ity, Town o	or Location							T.	10d. Inside City Limits	
/aryla	tified	rectc	MD					IMOR	ZE							1 Yes 2 □ No	
the N	pe no	Ö	10e. Street and Nur					10f.	Zip Code				10g. 0	Citizen of V		A	_
death with	must be notified at	Funeral Director		IXTON			. 1	10.111 5	212		1100				US,		_
Sr dea	niner	by Fu	11. Marital Status1 \(\sum \) Never Marr	ried 2 Married	Armed F	cedent Ever in U orces? 2 🔀 No	.S.	13. Was De If Yes, s	cedent of F pecify Cub	lispanic O an, Mexica	rigin? (Spec an, Puerto I	cify Yes or No Rican, etc.))		e - Americ k, White,	can Indian, etc.	
)03(Irs afte	Exar	ed t	3 🗆 Widowed	•	If Yes, G Year or I	ive		1 ☐ Ye	s 2 🔀 No	Specify	y:			Specify:	BU	9CK	
15-0	edica	plet	(Spe	15. Decedent's ecify only highest (d)	1 (0	Decedent's L Give kind of	work done	during mo	st of workin	ng	16b.	Kind of Bu	ısiness In	dustry	
21215-0036 within 72 hours after death with the Maryland giene.	the M	Completed	Elementary/Sec		College (1-4 or 5+)		fe. DO NOT SSE p					10	CKE	IN	SULATOR	
nd 2	vent,		17. Father's Name ("					1	her's Name	(First, Middle	e, Maidei	n Surname	e)		_
ylaı Ild be	ratic e	욘	ALLEN	-		K				EAT	ethe	7 PER	ARS	on			_
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after deal the marked other than "natural", or iter	traun		19a. Informant's Na ROWENA			1166	19b. I				_	Route Numb				Code)	
Te, 1 and f Heal	other		20a. Method of Disp	position		20b.		Disposition (Name of		- YDA	TO, M	20c.	Location -	City or To	own, State	_
imo Page nent c	ury or			☐ Cremation 3 5 ☐ Other (Spec		n State	cemetery,	wn Ce	or otner pia EMETE	RY	1/25	5/12	B	ALT,	MOR	et, MD	
Baltimore, I permit. Page 1 and 3 Department of Heall Important: if item 2	any inj		21. Signature	al Service Lice				22. Name	and Addre	ss of Faci	lity VA	MGHI	VG	REET	NEF	UNERALSO	US
	10 O	-	23a. Part 1. Enter t	the disease or co	-	caused the dea		1490						, ME	0 2	Approximate	-
Physic		. ,	shock, or hea Immediate Cause (ırt failure. List only (Final	one cause on e	ach line.			,	19, 300,1 0	5 cardiae of	respiratory a				Interval Between Qnset and Death	
Med Med	dical		disease or condition resulting in death)	n 🗾	a. Due to	(or as a consec	of)	T CUI	ure							WHENDWY.	_
Exam		<u>.</u>	Sequentially list co	onditions,		Mmor			בווכם	m					-	Days	
Z 18.8	ısit	Examiner	cause. Enter Unde Cause (Disease or	erlying injury		(or as a consec	· ~	ives	(00	IPS						nonths	
an and	ırial-transit	Exa	that initiated events resulting in death)	ts	U	(or as a consec			CUM								_
60 for the be of hysicial	he bur	dical			d												
68760 certificate be nding physici	se as t	/We	IF FEMALE:		23c. If ves. or	itcome of pregn	ancv									<u> </u>	_
Box death c	d for u	Physician/Medica	23b. Was decedent in the past 12 to 1 \(\sum \) Yes \(2 \sum \)	months?	1 ☐ Live 4 ☐ Pre	e Birth 2 🔲 Fe gnant at time of	tal death	3 Ectop 5 Other		cy				23d. Dat Moi	e of deliv nth	ery Day Year	
O. E	tacher	Phys	9 🗆 Unknown	1	9 🗆 Uni							1			_		-
S, P.	pe de	ģ	Part II. Other signif	HENSION	contributing to	death but not re	sulting in	the underlying	ng cause gi	ven in Par	τ I.	1				ne cause of death?	n
ords requir	should	letec	1.710.	10(14.01)	<u> </u>							24a, Was				psy findings available	Ш
(Reco	age 2	Completed by										auto	opsy formed?	F d	orior to co leath?	mpletion of cause of	
al Fian; Ti	ctor, p		25. Was case referre	ed to medical					26. P	lace of De	eath (Check	1 ☐ Yes only one)	2 14/1	No 1	Yes	2 LI NO	
f Vit	al dire	욘	1 ☐ Yes 2√	No		Inpatient 2				4 ∟ №	Nursing Hor	me 5 🗆 Res	idence	6 🗆 Othe	er (Specify	9	
in O	funer	cate	27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending Investigati		e of injury hth, Day, Year)	28b. Tin inju		28c. Injur work	yat ≺? Yes 2.[_ 1	8d. Describe	how inju	ary occurre	ed		
Division of Vital Record rater death. The law requal rater death.	by the	ertiji	3 Suicide 4 Homicide	6 Could not determine	be 28e. Plac	e of Injury - At h ling, etc. (Specis	ome, farm		_						er or Rura	Route Number,	
Div oital or urs aft ral Dir	lled in	<u>a</u>										City or To	-	,			
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after clearth. To the Funeral Director: After this certificate has been signed by the attending physicia	eted f	Medical Certificate:	(Check 2	Certifying Ph Medical Exar	miner: On the ba	isis of examination	on and/or i	nvestigation,	in my opini	on, death o	occurred at	the time, date	and place	e, and due	to the ca	use(s) and manner stat	ed.
V ithin	comp		29b. Signature and		7	. ~	19 141011100		29c. Licens		io and place	s, and add to a		ate signed			_
1			> /X	rantat	V	N.D			T2	59:	24		C	119	18	2012	
- L	1		30. Name and addre	Patel	completed cau	se of death (Iter	n 23a) (Ty	pe, Print)	Ba	Itm.	orc	Ma	rul.	202	2	1229	
	State	е	31. Date filed (Mont	27017	32.	Registrar's Sign	Rure	,			<u> </u>	1 101	7				_
Re	gistra	r	JAN D	0 -01- X	and a	1. 1	20 m										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WAYNE COX 0300 01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year AN 18 19 579-54-8178 **Director** 68 JAN 1943 WASHINGTON, DC Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits or 28a-f sho notified at 10c. City, Town or Location death with the Maryland Director 1 X Yes 2 □ No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 12015 HUNTERTON STREET 20774 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates BLACK "natural", Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MEAT MANAGER PRIVATE Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) မ JAMES T. COX SR. GLADYS ELIZABETH WATERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUISE COX/WIFE 12015 HUNTERTON STREET UPPER MARLBORO, MARYLAND 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State HARMONY CEMETERY 1/21/2012 LANDOVER, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease shock, of heart failure. L Immediate Cause (Final , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Onset and Death Physician PNBUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIFFICILE COLITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 MNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 Tes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063703 01/16/12 FGOO CHEROLL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAKOMA PARK SABYAR ACM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State granked

Registrar

1 - For State Registrar Decedent's Nam

29a. Certifier (Check

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PREETAM JOLEPALEM M.D., 7601
te flight 12 3 2012 32. Registrar signatural and a signatural signatural and a signatural signatural and a signatural signatura signatural signatural signatural signatural signatural signatur

29b. Signature and title of certifier

Director

Funeral

Completed by

Be

P

Examine

Physician/Medical

Completed by

To Be

Certificate:

Medical

Physician/

Medical

Examiner

Funeral

Director

28a-f show

		State of N	Maryland /	Depa	ırtme	nt of H	lealth	and M	1ental Hv	giene	е		
For State Registrar			riai y iai ia i			te of D				Reg. N	00	112	01301
Decedent's Name	(First, Middle, Las	st)							2. Date of De		-2) (_	3. Time of Death
Nona Mar	ie Cole								JANUA	RY^{D}	19,	2 0 1 2	10:12P M
Facility Name (if n	ot institution, give	street and number)		4b. City	, Town, or	Location	of Death		40	c. County	of Death	
		MEDICAL	CENTER	≀	TOV	VSON					BAL'	TIMO	RE
Social Security Nur			Age (In yrs. last b	irthday)	If Unde Months	er 1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da			9. Birth Cou	nplace (State or Foreign ntry)
20-22-30 sual Residence of		□ M ŽŽF	87	Yrs.					Mar. 5			Mar	yland
	10b. County		10c. City, To	wn or Loc	ation								10d. Inside City Limits
MD	Ba1t	imore	Re	eiste	rsto	own							1 🗆 Yes 💥 No
Street and Numb						ip Code				10g. C	itizen of	What Cou	intry?
319 Le	yton Roa	đ			2	21136				_	J.S.		
Marital Status		12, Was Deceden	t Ever in U.S.	13. W	/as Dece	dent of His	spanic Or	igin? (Spe	cify Yes or No-				can Indian,
Never Marrie		Armed Forces	X _{No}			ecify Cubar 2 XX No			Rican, etc.)			ck, White	
Widowed 4		If Yes, Give Year or Dates			⊔ Yes	ZANO	Specify				Specify	Whi	te
(Speci	15. Decedent's Edify only highest gra		16	Ba. Deced (Give k	ind of wo	ork done d	ation uring mos	st of worki	ng	16b.	Kind of B	lusiness/li	ndustry
Elementary/Secon	idary (0-12)	College (1-4 o	r 5+)	life. DC	NOT us	se retired) nemak	_)wn H	Iomo
Father's Name (Fi	ret Middle Laeti				ПОП	iemak		sor'o Nors	e (First, Middle,	Majde-			OHE
Joel Br								_	Oster	warden	JUITAIN	~ <i>/</i>	
	ne/Relationship (T)	vpe. Print)	4	Ob Mailin	a Addres	e /Straat a			I Route Numbe	r City o	or Town	State 7in	Code)
		n (Daught			_				erstow				
. Method of Dispo	sition		20b. Place	of Dispos	sition (Na	me of			Date				own, State
	Cremation 3 Contact (Specif	Removal from Sta	te Garr	ison	affor	est ^{place}	e)	Ja	n. 24,				
_	ral Service Licens		1 vete	rans	Name a	nd Addres	s of Facili		012 hardt 1	-un∈	ral	Chan	ls, MD el, P.A.
MANY	Roma	The -		1								_	MD 21117
a. Partier the	e disease, or comp	plications that caus	ed the death. Do									T	Approximate
nediate Cause (Fi	inal	ne cause on each I RESPI	RATORY	FA]	LUR	RE							Interval Between Onset and Death HOURS
ease or condition ulting in death)	-	a	s a consequence									-	21 1100110
		•	FAILU	,									72 HOURS
quentially list cond ny, leading to imm	ditions, nediate	Due to (or a	s a consequenc	e of):								\rightarrow	
ise. Enter Underly use (Disease or in t initiated events		C. —											
ulting in death) La	ast	Due to (or a	s a consequenc	e of):									
		d											
EMALE:										Т			
. Was decedent p	rogitant	23c. If yes, outcom	e of pregnancy	ath 3 \square	Ectonic	pregnance	v					ate of deli	,
in the past 12 m			at time of death		Other (s		,				Mo	onth	Day Year
9 Unknown									1	1			
	ant conditions co	ontributing to death (T A	but not resulting	g in the ur	nderlying	cause giv	en in Part	Π,			10		the cause of death?
HILE	TCATCE!	1.4.4							1 🗆	Yes 2			obably 4 🗆 Unknown
									24a. Was auto		24b.	Were auto	opsy findings available ompletion of cause of
										rmed?		death?	2 🗌 No
Was case referred	to medical					26. Pla	ice of Dea	ath (Check					
1 Yes 2	No	Hospital:	atient 2 ER/0	Outpatient	3 🗆 D	Othe	r: 4 🗆 N	ursing Ho	me 5 Resi	dence	6 🗌 Oth	er (Specif	(y)
		28a. Date of in	jury 28b	. Time of	1:	28c. Injury	at		28d. Describe I				
- 4	E Donding	(Month. F.	Day, Year)	injury	- 1	work	7				,		
Manner of Death Natural Accident Suicide	5 ☐ Pending Investigation 6 ☐ Could not be	(Month, E	Jay, Year)	injury	М	work'	? Yes 2 🗆	No					

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OSLER DRIVE TOWSON, MD 21204

29d. Date signed (Month, Day, Year) 0

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 01309

amela Crabill		1- For State	State of	Maryland		irtment of <i>tificate</i> of		and	Mentai	Hygien		, No.	12 0100
Physici	an/	1. Decedent's Name (Fire	st, Middle,Last)								of Death		3. Time of Death
ledical Exami	ner	rancia bac				<u> </u>					th Jary 15	, 2012	2130 hrs
		4a. Facility Name (if not i Harbor Hospital		treet and number)			4b. City, Tow Baltimoi	re				4c. County of De	
Funeral Director		5. Social Security Number 216-21-159 (e (In yrs. Ia 25	ast birthday) Yrs		Year Days	If Under 24 Hours	Min.		For	Birthplace (State or reign Country) Maryland
		Usual Residence of Dece	edent	- A-						Fid	y J	1000	
w any		10a. State 10b.	County		- ,,	Town or Locat	ion						10d. Inside City Limits 1 vyYes 2 No
Aaryland 28a-f show 1 at once,	tor	MD 10e. Street and Number			Bal	Ltimore	10f. Zip Co	nde.			100	g. Citizen of What C	2121
ith the Maryland 23a or 28a-f sho cotified at once	Director			-			2123					.S.A.	
with the second		2813 Hinsda 11. Marital Status	1	2. Was Decedent			s Decedent o	of Hispa			s or No-	14. Race - An	nerican Indian, Black,
death or iten	Funeral	1 X Never Married 2	1		X No		es, specify C			erto Rican, e	etc.)	White, etc	c.
s after iral",	Ď	3 Widowed 4 15. Decedent's Education	Divorced If	Dates:	nlotod\	1	Yes 2xX			l of work don	. 1	Specify: W	hite
2 hour	Completed	Elementary/Secondary		College (1-4 or 5			ost of working					TOD. TAITE OF BUSINES	33 II dustry
036 rithin 72 ane.	mple	Grade 10				Wait	ress					Food Se	ervice
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner		17. Father's Name (First,						18.				aiden Surname)	
212' ald be Mental	To Be	Brian K. Ci		e, Print)		19b. Mailing	Address (Street a		n N. G		er, City or Town, St	ate, Zip Code)
MD d 2 sho lith and n 27 is		Susan N. Cı	rabill	/ mothe	r	1009	7th S	tree	et La	aurel,	Mar		707
		20a. Method of Disposition 1 Burial 2 X Cr	on	Removal from Sta		Place of Dispos rematory or other	ition (Name o			Date		20c. Location - City	or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 0	Other Specify:			Arund	el Cre			1/23/2	012	Odenton,	Maryland
Ball Permit Depart Impor		21. Signature of Furieral	. J. 20707										
Physician		23a. Part I. Enter the dise	Approximate Interval										
/Medical		failure. List only one Immediate Cause (Final		ine. Shronic N	arco	tism							Between Onset and Death
- Adminior		or condition resulting in o	death) Due	e to (or as a conse	quence of	F):							
	Je.	Sequentially list condition if any, leading to immedia	iate Due	e to (or as a conse	quence of	j):							
. 10.1	aminer	cause. Enter Underlying (Disease or injury that in events resulting in death	itiated ^{C.} —	e to (or as a conse	quence of	·):							
and and transit	al Exa		d.	-00	07		026 /	2 1	2				
O, e be exc ysician burial -	edical	X UNPENDED		MENDED 23a,	_		3926 4-	-2-1	Z Sm				
876 tificate ng phy as the l		IF FEMALE: 23b. Was decedent pregn past 12 months?	nant in the	23c. If yes, outcom	ne of pregr		tal death	3 🗌	Ectopic pre	egnancy		23d. Date of deliver Month	very Day Year
Ox 6876 eath certificate eath certificate attending phy for use as the b	Physician/N		✓ Unknown	4 Pregnant at	time of dea	ath 5 Ot	her (Specify)						
D. B. t the de by the	Phy	Part II. Other significant		ntributing to death	but not re	esulting in the u	inderlying cai	use give	n in Part I.	236	e. Did tob	acco use contribute	to the cause of death?
ires that	d by									_ 1	Yes	2 No 3 P	Probably 4 VI Unknown
ords w requi s been should	Completed									24	a. Was an autopsy	prior t	autopsy findings available to completion of cause of
Reco	E									1	perform Yes 2		l? Yes 2 ☐ No
tal Recient The certificate rector, page	B	25. Was case referred to examiner?	medical Hos	pital:		ER/Outpatient		IO#		eck only one		·	
ing Phys After this	P	1 ✓ Yes 2 27. Manner of Death	No	28a. Date of Inju	y	28b. Time of le			t Work?	ursing Home 28d. De		esidence 6 Ot w injury occurred	her:
OD Creating	ţi	1 X Natural 5	Pending Investigation	(Month, Day,Ye	ear)		1	Yes	2 No				
ivisi lor Att after de Direct	Certification:	2 Accident 3 Suicide 6	Could not be	28e. Place of Inj	ury - At ho	ome, farm, stree	et, factory, off	fice build	ding, etc.		cation (Str Town, Sta		Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fueeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		4 Homicide 29a. Certifier 1 Certifier	determined	(Specify)	, knowless-	re death acc	rad at the 1:	no dete	and place	and due to "	ha causes	s) and manner as s	tated
To the Hos within 24 h To the Fuc completely	Medical		ical Examiner:Or	n the basis of exam	nination ar	nd/or investigat	ion, in my op	inion, de	and place, eath occurr	ed at the tim	e, date ar	s) and mariner as s nd place, and due to	o the cause(s)
To with	§	29b. Signature and title o		d manner stated.		-	- 1	cense n				29d. Date signed (i	Month, Day, Year)
		Alla	Bull	11/3			°	.C.M.	E.			January 16, 20	012
ϕ		 Name and address of Melissa Brassell 	i - 01	pleted cause of de stant Medical			. Baltimor	re Stre	et. Balti	more. MD	21223		
/ St	ate	31. Date filed (Month, Da	y, Year)	32. Registrar					,		0		
Regist		JAN 2 3 20	040										

ORIGINAL

DHMH 17 Rev 1/2001

UÇME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Ma	aryland / Depa <i>Cer</i>	artment of H tificate of L		l	Reg. No. 20	12 01310
Physic /Medi Examin	cal	Decedent's Name (First, Middle, Last) A. Facility Name (If not institution, give state)	street and number)	Co	4b. City, Town, or	Location of Deat	2. Date of Dea Month Januas	Day	Year 3. Time of Death 114 38 P M f Death
		The Johns Hopkins Ho			Baltimore			N/A	
Funeral Director		IV/A	IM OFFE	e (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	v. Year)	9. Birthplace (State or Foreign Country) L.I. Bahamas
Fe, INTALYIANG Z1Z15-UU36 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Grand Ba 10e. Street and Number 4 Island Circle 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 8th Grade 17. Father's Name (First, Middle, Last) Joe Burrows 19a. Informant's Name/Relationship (Ty Patricia Johnso 20a. Method of Disposition	16a. Dece (Give life.) 19b. Maili ter) 252	Free 10f. Zip-Code POE Was Decedent of H If Yes, speafly Cuba 1 Yes 2 No dent's Usual Occup kind of work done DO NOT use retired Executiv Moodhil position (Name of	BF41651 dispanic Origin? (san, Mexican, Puer Specify: pation during most of we during most of we san Susan and Number or F	Specify Yes or No- to Rican, etc.) orking e Keep ame (First, Middle Knowle	Specify: 16b. Kind of Bus Hotel Maiden Surname s er, City or Town, S Glen Bu	American Indian, White, etc. Black Siness/Industry	
Page nent o ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		The cra	nnd or Bank al Park	01/	28/12	Free Po	Grand ort,Bahama
permit. Departr Departr Importa any Inje		23a. Part 1. Enter the disease, or compl	V. Will	camo 21	40 N. F	'ulton .	Ave., B	altimor	Home PA ce, MD21217
Physician / Medical Examiner Associated and the behavior of the partial franching the p	dical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the conditions of the conditio	Due to (or as	Α.	urysk	^			Interval Between Onset and Death
vical necolds, r.O. box oord sician: The law requires that the death certificate certificate has been signed by the attending phys lirector, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	☐ Ectopic pregnanc ☐ Other (specify)	y		23d. Date Mon	of delivery th Day Year
requires that the requires that the seen signed by should be detact	þ	Part II. Other significant conditions co	ntributing to death b	out not resulting in the	underlying cause g	iven in Part I.	23e. Did t	1	bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
The law req	Completed						24a. Was autor perfo 1 Yes	osy pr rmęd? de	/ere autopsy findings available rior to completion of cause of eath?
VITAL ician; T ertificat ector, p	Be	25. Was case referred to medical examiner?	Hospital:		Oth	er.	eath (Check only o		
Phys rthis o	2	27. Manner of Death	28a. Date of Inju	ry 28b. Time o	of 28c. Injur	y at		dence 6 Other	
DIVISION OF the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	(Month, Day 28e. Place of inju- building, etc	ury - At home, farm, str	_	k? Yes 2 □ No	28f. Location (er or Rural Route Number,
Hospital or Attendi 24 hours after death Funeral Director: A etely filled in by the f		29a. Certifier 1 X Certifying Phy	sician: To the best of	of my knowledge, deat			ce, and due to the	cause(s) and mar	
he Ho in 24 h he Fui ppletely	Medical	one)	ner: On the basis of and manner sta				curred at the time,		and due to the cause(s)
To the within 2 To the comple	Σ	29b. Signature and title of certifier		<u> </u>	29c. Licens				(Month, Day, Year)
		30. Name and address of person who c	ompleted cause of a	leath (Item 23a) (Type		2-000		Januari	y 16 2012
		Christopher	Gilbe	1 >0		600	North Wo	lfe St, Bal	timore, MD, 21287
Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	parker				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Month Day Physician/ PM 150 110 French Cox, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** 579-64-8558 Hours Min. (Month, Day, Year) Director 1 SM 2 - F 60 Feb. 23, 1951 D.C. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2X No Hyattsville MD P.G. County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 4090 Hanson Oaks Drive 20784 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12 Was Decedent Ever in U.S. Was Deceue... Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X If Yes, Give Year or Dates. Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) System Analyst Software Develope Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earl F. Cox, Sr. Gloria Swanson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shari Mills (ex-wife) 4090 Hanson Oaks Dr, Hyattsville, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State On-Site Cremation | 21 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Joseph H. Brown Jr.
2140 N. Fulton Ave, Funeral Home, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law After this certificate has I autopsy perform 2 No 1 Yes Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Hospital: 2 No Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6/2 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Broun egistrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		-	For State	State of iviary		artment of F tificate of E		іментаї пу	-	010	01212
			Registrar 1. Decedent's Name (First, Middle, La.	st)		incate or E		2. Date of De		UIZ	3. Time of Death
	Physicia Medic		John A.	DiPaolantoni	.0			Janua:	ry 17,	2012	8:55 a ^M
- TERRY	Examin		4a. Facility Name (if not institution, give			4b. City, Town, or			4c. Co	unty of Death	
-			9746 Reese Far 5. Social Security Number 6. S		yrs. last birthday)	Owin	ngs Mill If Under 24 Hrs		rth		imore place (State or Foreign
	Funeral Director			™ 2 □ F 86	Yrs. last Dirtifuay)	Months Days	Hours Min	. (Month, Da	ay, Year)	Cour	ntry)
	, MC		Usual Residence of Decedent					March	6, 192		PA
	ryland •f sho	to lo	10a. State 10b. County		c. City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	ne Ma or 28a notif	Director	MD Balt 10e. Street and Number	imore		Owings M:	ills		10g Citizer	n of What Cou	
	23a c	eral	9746 Reese Far	m Road		I .	117		3	U.S.A.	Titl y s
	items er mu	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (S	Specify Yes or No-		Race - Ameri	
36	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give		Yes 2 No		to riicari, etc.)		Black, White, ecify:	
21215-0036	atura cal E	Completed by	3 - Widowed 4 - Divorced	Year or Dates.	16a, Deced	lent's Usual Occupa	ation			of Business/Ir	hite
215	n 72 h e. an "n Medi	du	(Specify only highest gr Elementary/Secondary (0-12)	rade completed) College (1-4 or 5+)	(Give I	kind of work done d O NOT use retired)	luring most of wo	orking	lob. rand	or Buomicoon	idootiy
2	ygiene ygiene her th t, the	ပို	12			Chef			1	Restau	rant
Maryland	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Mec	To Be	17. Father's Name (First, Middle, Last)	DdD 1 +				ame (First, Middle			
Ž	ould b		Joseph A	. DiPaolant		ng Address (Street a	-	endora	Sarmo		Cadal
	and 2 sho Health ar tem 27 is	ĺ	Elizabeth M. DiP			·6 Reese				11s, M	
Jre,	of Health fitem 27		20a. Method of Disposition	20	0b. Place of Dispo		1	Date		tion - City or T	
ï.	Page ment ant: N		1 ☐ Burial 2 🕱 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		arroll C			21/ 12	Hamps	stead,	Maryland
Baltimore,	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Sovice Licen	see m Jen	161.	. Name and Addres	•	11824 R E Reist			Road 21136
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of		death. Do not ente	er the mode of dying	g, such as cardia	ç or respiratory a	rrest,		Approximate Interval Between
	hyrician/		Immediate Cause (Final disease or condition		auguste	or the	18 for	la			Onset and Death
	Medical Examiner	П	resulting in death)	Due to (or as a con	isequence of):						
		ner	Sequentially list conditions, if a y lead of a historical set	b. Sum for as a con	encylenda cffr						
Ne,	uted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
P	icate be executed physician and is the burial-transit	al E)	resulting in death) Last	Due to (or as a con	sequence of):						
092	ta d ±	edical		d							
89	ath certific attending I for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	egnancy				230	d. Date of deliv	/erv
Вох	death death e atten	Physician/N	in the past 12 months? 1 Yes 2 No	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		Ectopic pregnanc Other (specify)	:y			Month	Day Year
P.O. I	es that the dea signed by the a I be detached I	Phy	9 ☐ Unknown Part II. Other significant conditions of		at resulting in the u	nderlying cause giv	en in Part I	ogo Did	tohoooo uoo		he cause of death?
s, P.	ires that signed	Completed by	allerere de			Cleur	off in Fact.				bably 4 Unknown
Records,	tw require as been si 2 should	olete			ł			24a. Was	an 2	24b. Were auto	ppsy findings available
Rec	The lav	Jon Som							ormed?	death?	ompletion of cause of
ta	ician: The certificate rector, paq	Be (25. Was case referred to medical examiner?		vance is		ace of Death (Che	-			
of Vital	Physi this c ral dir	은	1 Yes 2 No	Hospital: 1 Inpatient :	2 ER/Outpatier		4 L Nursing	Home 5 Resi			y)
n o	ding th. After	cate	1 Natural 5 Pending 2 Accident Investigatio	(Month, Day, Yea		28c. Injury work' M 1 \square	/ at ? Yes 2 □ No	28d. Describe	how injury oc	ccurred	
Division	l or Attendir after death. Director: Af I in by the fu	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - /						umber or Rura	al Route Number,
Οį	ital or A urs after ral Directled in by			building, etc. (Sp				City or To			
	the Hospital or Attending Physician: The law requires that the death certif hin 24 hours after death, hin 24 hours after death, the Funeral Director: After this certificate has been signed by the attending the Funeral Director. After this certificate has been signed by the funeral director, page 2 should be detached for use a mpletely filled in by the funeral director, page 2 should be detached for use a	Medical	(Check 2 ☐ Medical Examonly ope) 3 ☐ Certifying Nur	vsician: To the best of my k niner: On the basis of examir se Practitioner: To the bes	nation and/or invest	tigation, in my opinio	on, death occurred	at the time, date	and place, and	d due to the ca	ause(s) and manner stated.
_	To the within 2 To the comple		29b. Signature and title of certifier			29c. License	number		29d. Date of	igned (Month,	
0				MAIS	// · · · · · · · · · · · · · · · · · ·	1 V 2C	0806			40/0	0/2
	10t'		30. Name and address of person who		(Item 23a) (Type, P	CV- D	Reisle	uslan u	4)	2(136	
	Sta Registra	te ar	31. Date filed (Month, Day, Year)	32. Registrar's	ignature	1					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5230 A M Patricia Ann Davis 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Prince George Doctors Hospital Lanham . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) **Director** 215-46-0160 1 □ M 2 🗓 F 67 Sept 6, 1944 Washington, DC Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County items 23a or 28a-f sho ner must be notified at 10a. State 10c. City, Town or Location Director 1 X Yes 2 No MD Greenbelt Prince George 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20770 3 Woodland Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 14. Race - American Indian 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: White Completed 3 X Widowed 4 □ Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Communications Frame Attendant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rachael Rita Capone Carl A. Oliver, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 917 R Street, NW, Washington, DC 20001 John Oliver / brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mary's Cemetery Jan 19, 12 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Fihal Interval Between Onset and Death evere Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Sue to for the propression and I-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 physician s the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 X6 Day g Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown by the Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, Completed Respiratos Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has page death? 2 **]** 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 1 No Hospital Other: 1 Yes ER/Outpatient 3 DOA ျ 1 Impatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer (Month, Day, Year) work?
1 Yes 2 No injury 1 Watural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (*Month*, *Day*, Year) 29b. Signature and title of certifier MDD 60611 of person who completed cause of death (Item 23a) (Type, Print) MO 8118 Good Lucilld, Lanham, MD. DINWI 31. Date filed (Month, Da Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 4 2012 JANUARY 5:05 A_M DAVID JOHN DZIEDZIC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NATIONAL INSTITUTES OF HEALTH MONTGOMERY BETHESDA Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo Sept. 4, 9. Birthplace (State or Foreign Country) Illinois 7. Age (In yrs, last birthday) Funeral Year) 1962 XXM 2 □ F Days Hours Min. Director 573-53-4981 49 Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Vienna Virginia | Fairfax 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2004 Annies Way 22182 U.S.A 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2XX No If Yes, Give Year or Dates. 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Association Elementary/Seconday (0-12) College (1-4 or 5+) enior Vice President of Broadcastors 4 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert C. Dziedzic Sharlene M. Dundas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane L. Kraft-Dziedzic-Wife <u> 2004 Annies Way, Vienna, Virginia 22182</u> Place of Disposition (Name of cemetery, crematory or other place)

nev & King Services Jan. 19,2012 Chantilly. Virginia

nev & King Funeral Home, Inc. 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Feneral Service Licensee Downer Gary R. Mira Wek CCO 508 171 W. Maple Ave. Vienna, Virginia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Glioblasterac year disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): physician Physician/Medical that the death certificate be the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No Year Month Day signed by the aid 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ or Attending Physician: The law requires Completed 1 ☐ Yes 2 🗹 No 3 🗋 Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☒ No Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No မြ 1 Npatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 H within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) O4854L1 14,2012 PERRY M GMITH, MD

DHMH 17 Rev 7/2009

State Registrar

20

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

of Vital

Division

32. Redistrar's Agnature

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PERRY M.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per inf e925 3-16-12 yt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JAUNARY 18, 2012 Physician/ EUGENE DICKLER 6:30 A M Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE ARDEN COURTS BALTIMORE ocial Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 X M 2 - F Months Days Hours Min 03/17/1925 2**:5-20-0029** **Director** 86 MD Usual Residence of Decedent or 28a-f show notified at 10b. County lid be filed within 72 hours after death with the Maryland Mental Hygiene. 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2x No MD BALTIMORE OWINGS MILLS "natural", or items 23a or a dical Examiner must be no 10e. Street and Number 10g. Citizen of What Country? Funeral 4730 ATRIUM COURT, #175 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 IX Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. Completed 3√ Widowed 4 □ Divorced WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 OWNER TAVERN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM DICKLER JENNEY WEISBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra STEVEN BROWN/STEPSON 18517 GUNPOWDER ROAD, HAMPSTEAD, MD Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP 01/23/2012 TOWSON, MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. with) 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Demen disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of impury that initiated events Examiner Due to (or as a consequence of) and Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Box 68760 as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Souther (Specify) Assisted Living} \) 2, No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Jan, 18, 2012 D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Svite 4105, Tousua MD 21204 6701 NCharles 13/ack 32. Registra 's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 1 - State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RICHARD NORMAN De VOE Physician/ Month 9:35 AM Medical or Location of Death 4a. Facility Name (if not institution, give street and number) City, Town 4c. County of Death **Examiner** N/A sach more If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 🗆 F Months Hours Aug I, 1925 213-20-8455 86 "Pennsylvania Director Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location notified at Director Baltimore 28a-f Maryland Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be r ŏ Funeral 21207 6434 Gilmore Avenue USA "natural", or items idical Examiner mu Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11, Marital Status Armed Forces?

1 K Yes 2 No Black, White, etc 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify If Yes, Give W 2 Completed 3 Widowed 4 Divorced Year or Dates. er than "natur , the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Cloverland Dairy Milk Deliveryman Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname)
Wynola Burns 17. Father's Name (First, Middle, Last) ပ James De Voe 19a. Informant's Name/Relationship (Type, Print)
Mrs. Frances A. De Voe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 6434 Gilmore Avenue, Baltimore, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fawn Grove Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 1/23/2012 Fawn Grove, Pennsylvania 4 Donation 5 Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Signature of Fur eral Service Licensee Kevin E Ecker 237 E. Patapsco Avenue, Baltimroe, Maryland 21225-1856 M00175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Deat Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last sepsis use as the burial-transit signed by the attending physician and be detached for use as the burial-tran Due to (a) as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To Be Completed certificate has been s irector, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy performed? 25. Was case referred to medical director 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29d. Date signed (Month, Day, Year) Baltimores

DHMH 17 Rev 7/2009

State Registrar

Amend #26 per mD G923 1/23/12 TRT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death -ranklin Month Voor January 16, 2012 11 13Am **Physician** Louce /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth (Month, Day, Year) 08 - 29 - 40 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 M 2 V Director 217-40-0535 71 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 1 X Yes 2 □ No Director be notified 28a-f MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 23a USA 1019 N. 21205 Kenwood Avenue Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. African 1 Never Married 2 Married ō 1 ☐ Yes 2 ☐ No 21215-0036 Specify þ Specify: American 3 Widowed 4 Divorced Year or Dates: "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Private Duty Nursing 12th Grade 2yrs. Nursing Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hisant: If item 27 is marked oth Be Riley Franklin Mary Francis Lewis ည traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 int of Health at: If item 27 is Josette Fullard-Daughter 1019 N. Kenwood Avenue Baltimore, MD. Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Important: If any Injury or once. King Mem. Pk. 01-25-12 Randallstown, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 638 N, Gilmor Street Baltimore, MD 21217 meslan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) cardiovascular **Physician** therosclerot /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) Yes 2 □ No P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 □ No 3 □ Probably 4 ☑ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy has 1 ☐ Yes 2 🙀 No of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 | Inpatient Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 2 X∈R/Outpatient 3 □ DOA 2 ρ 28a. Date of Injury 27. Manner of Death
1 Natural
2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 120676 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins 4940 Eastern Avenue, Baltimore, MD, 21224 State balle Registrar

DHMH 17 Rev 1/2001 11595

#12-455

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death THURSTON FORD CHARLES Physician/ 4840 P M Tanuar 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S LANHAM DOCTOR'S HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) **Director** 226-36-4816 1 🗶 M 2 🗆 F 81 AUG. 27 1930 VIRGINIA Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Examiner must be notified 1 XYes 2 No PRINCE GEORGE'S CAPITOL HEIGHTS 0 10e, Street and Number 10g. Citizen of What Country? items 23a Funeral 7227 HYLTON STREET 20743 **USA** death 12. Was Decedent Ever in U.S.
Argued Forces?

1 Yes 2 MARINES
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 K Married 5 hours after Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Specify: AFRICAN AMERICAN Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highe st grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) SUPERVISOR BUILDING ENGINEER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ROBERT FORD GRACE FOSTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tran DOLLY MADISON FORD/WIFE 7227 HYLTON STREET CAPITOL HEIGHTS, MARYLAND 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) VETERANC CEMETERY: 1/24/2012 CHELTENHAM, MARYLAND 21. Signatur, 51 uneral Service Licen 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Expert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration premona disease or condition Medical resulting in death) Examiner Cardio pulmoney Sequentially list conditions, Examiner day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sician and burlal-trans Due to (or as a consequence of). resulting in death) Last Physician/Medical Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 | Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Carcinoma 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Adenocarinoma 24a. Was an autopsy performed? 1 Yes 2 No page Hospital or Attending Physician: The 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes 잍 1 ✓Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending ours after death. М 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number MDD 43446 Roter Calin 1/11/112 MD.

Registrar

DHMH 17 Rev 06-2011

State

32. Registrar's Signature

12150 Anapolis Road Sute 200 Glendle MD 20769

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

FARAHIFAR

31. Date filed (Month, Day, Year) 12

68760 Box (P.O. Records, **Division of Vital** within 24 hours a

To the Funeral C

completely filled

> State Registrar

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature 3 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NABILA FARHAT KHAN M.D. 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) JANUARY 18, 2012

4	2	~	A 1	68	
-	Z -	u	14	00	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michael Frederick F	Fink 1- For State Registrar	State of Marylar		nent of Ho		Mental H		eg. No. 20	12 0132
Physician/ Medical Examine	1. Decedent's Name (First, M	liddle,Last) Frederick	Fink, Sr				2. Date of Deat Month January 17	Day Year	3. Time of Death 0534 hrs
	4a. Facility Name (if not insti Rt 75 SB at Jones		ber)		ty, Town, or Lo pertytown	cation of Dea	th	4c. County of D Frederick	eath
Funeral Director	5. Social Security Number 212–98–7038	6. Sex 7.	. Age (In yrs. last b		Under 1 Year onths Days	If Under 24Hi Hours Mi	n .	1965 h(MM/DD/YYYY)	Birthplace (State or preigrification Country) DC
w any	Usual Residence of Deceder 10a. State 10b. Cou		10c. City, Tow	n or Location					10d. Inside City Limits 1 Yes 2 X No
the Maryland n or 28a-f show tified at once. Director	10e. Street and Number	Frederick			ederick Zip Code		10	og. Citizen of What	Country?
er death with the , or items 23a ov r must be notifia Funeral Di	9224 Oak 11. Marital Status 1 Never Married 2 X		dent Ever in U.S.				Specify Yes or No-		,S.A. merican Indian, Black,
s after deal nral", or it niner mus by Fur	3 Vildowed 4	Divorced If Yes, Give Yeer or Dates:	2 X No		2 🔀 No	specify:		Specify:	White
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Eygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Elementary/Secondary (0-	12) College (1-4			working life. D	O NOT use re	tired)		government
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medica Be Comple						.Mother's Nam	ne (First, Middle, N Rothlisbe	(laiden Surname)	
MD 21: 12 should b th and Men 1.27 is mar umatic eve			1	9b. Mailing Add				nber, City or Town, S ederick, N	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	20a. Method of Disposition 1 Burial 2 X Crema 4 Donation 5 Othe		n State crem	e of Disposition atory or other p County (ace)		Date /23/2012	20c. Location - Cit	
Balti permit. Departn Import	21. Signifure 15 heral Ser		Der					Tuneral Ho	
Physician /Medical	23a. Part I. Enter the disease failure. List only one ca	use on each line.		not enter the m	ode of dying, su	ich as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner	or condition resulting in deat Sequentially list conditions,		onsequence of):						
ted Insit Examiner	if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initiate	d c.							
executed an and al - transit ical Exa	events resulting in death) La	d	onsequence or).						
dician be e.	UNPENDED IF FEMALE: 23 West decoders assument	in the	tcome of pregnanc	;y				23d. Date of del	
D.O. Box 6876C that the death certificate I ned by the attending phys detached for use as the by by Physician/Me	23b. Was decedent pregnant past 12 months?	I I TIME DILL	nt at time of death	Fetal de 5 Other	sath 3 Specify)	Ectopic pregr	nancy	Month	Day Year
, P.O. E res that the signed by the be detached by by by the bed detached by the by the by Ph	3	nditions contributing to d	leath but not result	ing in the under	ying cause giv	en in Part I.			e to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the by ledical Certification: To Be Completed by Physician/Me							1 ✔ Yes	sy prior m <u>ed</u> ? deat	e autopsy findings available to completion of cause of h? Yes 2 No
f Vital Physician: or this certifical director To Be	examiner?	(Magnital)	patient 2 ER/	Outpatient 3		f Death (Check ther 1 Nurs		Residence 6 🗸 0	Other: Scene
ion of ttending Pl leath. tor: After the funeral		Pending 28a. Date of Jan 17, 20	Injury 28b (ay Year) 05	o. Time of Injury 29 hrs	28c. Injury	at Work? s 2 ✔ No		now injury occurred er of pickup tru	ck struck by another
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune fedical Certification:	3 Suicide 6 (Could not be 28e. Place	of Injury - At home, Major Road / I		ctory, office buil	ding, etc.	or Town, S		r Rural Route Number, City ytown, MD
To the How within 24 h To the Fun completely		g Physician: To the best of Examiner: On the basis of and manner sta	examination and/o		n my opinion, d	eath occurred		and place, and due	to the cause(s)
	29b. Signature and title of ce	the Vices	In the	0	O.C.M.			January 17, 2	(Month, Day, Year)
	30. Name and address of per Victor Weedn MD	JD Assistant Med	ical Examiner		altimore Str	eet, Baltim	ore, MD 2122	23	_
State Registra		32. Regi	istrar's Signature	Kind					
OCME 2006	0	OGME	0	RIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene

			= State Registrar		(Certifi	cate of L	Death		Reg. No.		
			1. Decedent's Name (First, Middle,	,		- ()			2. Date of De			3. Time of Death
	Physicia Medic		DOLORES	ELLZABET	H F	06L	EK.		Month	y IS	3 ZOIZ	. Z:05 PM
	Examin		4a. Facility Name (if not institution,	give street and number)		4b	. City, Town, or	Location of Dea			County of Deat	
			HARBOR HOSP.	LTAL			BALT	EMORE	=		N/A	
_	Funeral		5. Social Security Number	6. Sex 7. Age (n yrs. last birtho		Under 1 Year	If Under 24 Hr		th	9. Birl	thplace (State or Foreign
	Director		215-22-3128	1 □ M 2 🔀 F	83 Y	rs. Mc	onths Days	Hours Mir	Nov 17	^{1y,} 1928	Mar	thplace (State or Foreign untry) yland
	3		Usual Residence of Decedent									J.1.11K1
	and sho	힏	10a. State 10b. County	1	Oc. City, Town	or Locatio	n					10d. Inside City Limits
	Aaryl 8a-f tified	9	Maryland Anne A	rundel			H	Baltimore				1 🗌 Yes 2 🌡 No
	or 2	盲	10e. Street and Number			1	Of. Zip Code			10g. Citi:	zen of What Co	untry?
	with 23a ist b	era	600 C	resswell Avenue				21225		1	USA	
	ems er mu	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was I	Decedent of Hi	spanic Origin? (9	Specify Yes or No		14. Race - Ame	rican Indian,
5	or it	by	1 Never Married 2 X Marr	Armed Forces? ed 1 \(\sum \) Yes 2 \(\sum \) No	,			n, Mexican, Pue	rto Rican, etc.)		Black, White	
3	saft ral", Exa	듛	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 🗆	Yes 2 X No	Specify:		5	Specify:Whit	e
0000-0	hour natu lical	Completed		t's Education			s Usual Occupa			16b. Kir	nd of Business	Industry
<u>``</u>	n 72 an " Mec	ᄩ	(Specify only nigne: Elementary/Seconday (0-12)	st grade completed) College (1-4 or 5+)	11	ife. DO NO	OT use retired)	luring most of wo	orking			
<u> </u>	withi giene er th the		8	Ů Ů	I	Homema	aker			Hous	ewife & 1	Yiother
2	filed al Hy l oth vent	Be	17. Father's Name (First, Middle, L						ame (First, Middle		Sumame)	
<u> </u>	Jenta Jenta Irkec tic e	2	John John	Turner, Sr.				Elizab	eth Kohler	•		
ב כ	nould Ind Ind Ind Ind Ind Ind Ind Ind Ind In		19a. Informant's Name/Relationsh		19b. I	Mailing Ac	ddress (Street a	and Number or F	Pural Route Numb	er, City or	Town, State, Zip	Code)
Ž	d 2 slath a alth a 27 is 27 is r tra	. 10	James G. Fogler, S	r. (Husband)	60	OC Cre	esswell A	venue, Ba	1timore, M	arylar	nd 2122	5
ה ת	f He		20a. Method of Disposition		20b. Place of I	Dispositio	n (Name of		Date	20c. Lo	cation - City or	Town, State
2	age ent o nt: If y or		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S		Bayview	, cremator Creme	ry or other place atory, In	$\stackrel{(e)}{\text{lc}}$. $1/2$	3/2012	Balti	imore, Mar	ryland
Daltillion	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mertall Hygiene. Importment of Heath and Mertall Hygiene. Importment of Heath and Mertall Hygiene. and injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fundal Strate						Cully-Poly			•
0	permi Depar Impo any ir	- 13		2	MOO175							21225–1856
H			23a. Part 1. Enter the disease, or	complications that caused the								Approximate
			shock, or heart failure. List o Immediate Cause (Final	nly one cause on each line.				9,		,		Interval Between Onset and Death
. 0	hy i i i w Medical	i V	disease or condition resulting in death)	Due to (or as a c	C SHOW	CK						Onset and Beating
	Examiner		resulting in death)									
		7	Sequentially list conditions,	b. SMALL			ERFOR	CATLU	V			4 weeks
	p #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a c	onsequence of)	<i>j</i> .						
	cute	xar	Cause (Disease or iinjury that initiated events	c Due to (or as a c		١.						
	e exe	జ	resulting in death) Last	Due to (or as a c	onsequence on).						
3	v requires that the death certificate be executed to be executed to be easing by the attending physician and should be detached for use as the burial-transit	/Medical		d								
	rtifica ing p e as t	ĬŽ.	IF FEMALE:	1								
) <	h cer tendi		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	Fetal death			sy.		2	23d. Date of de	
֝֟֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	deat he at ed fc	Physiciar	1 Yes 2 No	4 ☐ Pregnant at ti 9 ☐ Unknown	me of death	5 ∐ Oth	her (specify)				Month	Day Year
;	t the by t	F.				Al	d. d	on in Doubl				
Ľ,	s tha gned se de	þ	Part II. Other significant conditio	-	not resulting in	the under	Tyling cause giv	ren in Parti.				the cause of death?
<u>.</u>	quire en si suld 1	ted	RESPIRATORY	FALLURE					. [] 1 🗀	Yes 2 L	」No 3 ∐ P	robably 4 Kunknown
2	w re	ple							24a. Was		24b. Were au	topsy findings available completion of cause of
necolus,	The la	Completed							perf	ormed? 2 🗷 No	death?	s 2 No
5	an: T tifica tor, p	Be C	25. Was case referred to medical				26. Pla	ace of Death (Ch		2 (Z.3%) NO	1 100	, 2, 110
	ysici s cer direc	10 B	examiner? 1 Yes 2 No	Hospital:	2 = ER/Outr	patient 3	DOA Othe	er;	Home 5 ☐ Res	idence 6	Other (Spec	ifu)
5	g Ph er thi		27. Manner of Death	28a. Date of injury	28b. Tir	me of	28c. Injury	/ at	28d. Describe			
	ndin ath. :: Aft	ca	1 X Natural 5 ☐ Pending 2 ☐ Accident Investig		rear) Inji	ury N	work √l 1 □	? Yes 2 🗆 No				
ה ה	Atter	Certificate:	3 Suicide 6 Could 1	not be 28e. Place of Injury		n, street, f	factory, office		28f. Location	Street and	Number or Ru	ral Route Number,
DIVISION OF	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		- I Homical acterni	building, etc. (Specify)				City or To	wn, State)		
-	spit hour: nera 1 fille	Medical		Physician: To the best of my								
:	e Ho e Ful e Ful	Med	(Check 2 Medical E	kaminer: On the basis of examiner: To the be	mination and/or i	investigati	on, in my opinic	on, death occurred	d at the time, date	and place,	and due to the	cause(s) and manner stated.
	No the sound of th	-	29b. Signature and title of certifier		.,	J ,	29c. License				e signed (Month	
			Mustine We	ganton, MI			RES	001		Jan	100/ 1	8 2012
			30. Name and address of person v	9.0		/pe, Print\		001		JAFA		5 01-
			CHRISTINE					I HAM	WED ET	255	RAITER	005 MN 7.1770
	Stat	ie.	31. Date filed (Month, Day, Year)	37. Registrar's	Signature	1	, 1 36UY	11/1///	VEN SI	1001	1 WILLIAM	NY (1-11) 0102)
	Ottal	-	COMMI	7117 1	1	1	//					

rowes **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5516 Bluecoat Lane Columbia 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min 1 □ M 2 🔽 F 220-42-8787 68 April 25, Director 1943 Usual Residence of Decedent 10c. City, Town or Location 10a. State "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Directo Maryland Columbia Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Item. or any Injury or other trainmain. 5516 Bluecoat Lane 21045 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married If Yes, Give Year or Dates: þ 1 ☐ Yes 2 X No Specify: 3₺ Widowed 4□ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Director of before Elementary/Secondary (0-12) College (1-4or 5+) and after School programs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Studivant Nannie Blackwell ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5516 Bluecoat Lane Columbia, Maryland 21045 Jada A. Graves (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery 1-26-2012 22. Name and Address of Facility 21. Signature of Euneral Service Licenses 5555 Twin Knolls Road Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) Y /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ Completed 24a. Was an performe 1 Tyes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner' 1 ☐ Yes 6لال⊒ 2ر 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manual of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 □ No Director: d in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a, Certifier Medical

and manner stated.

ted cause of death (Item 23a) (Type, Print)

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death

Virginia

1 ☐ Yes 2 🙀 No

10d. Inside City Limits

Birthplace (State or Foreign Country)

201

U.S.A.

Black

14. Race - American Indian, Black, White, etc.

Education

Howard

Ellicott City, Maryland Witzke Funeral Homes. Inc. Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 2 No 2 **N**o 1 ☐ Yes Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Registrar

State

(Check only one)

31. Date filed (Month, Day, Year)

STRAUIP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2ัก็ 2012 Arta Gartrell P^{M} 5:20 January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll Dove House Westminster Social Security Number 7. Age (In yrs. If Under 1 Year If Under 24 Hrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year 1 □ M 2 🖾 F Months Days Hours Min. Director 217-28-7404 MD Ĭ923 March Usual Residence of Decedent fshow should be filed within 72 hours after death with the Maryland is and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3235 W. Old Liberty Rd. 21776 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. <u>y</u> 1 Never Married 2 Married Yes 2x No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 x Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Shipping/Receiving Unknown Random House Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Frizzell Helen Harn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health s Vanessa G. Chrisafis (Daughter) 100 W. College Terrace Frederick MD 21701 item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Bethany Cemetery Jan 24, 2012 New Windsor, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenson 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ respiratory disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year ☐ Pregnant ☐ Unknown Pregnant at time of death 1 Yes 2 9 Unknow been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Congestive heart failure 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an his certificate has b Il director, page 2 sl 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Cher (Specify, 2 No 1 🗌 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral of 28a. Date of injury (Month, Day, Year) Hospica 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 Records, P.O. Division of Vital or Attending a erdeath. Director Aft dibyth fur

To the Hospital or within 24 hours at To the Funeral Discompleted filled in

29a. Certifier 1- Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) D 15552 1/22/12 M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Paisutz m.D. 826 washington Rd. Ste 204

Westminster md. 21153

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 2 3 2012

Registrar's Signatu sark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#8perFH, G923, 1/23/2012
State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John S 130 2 gea Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** COURTLAND GARDENS BALTIMORE BALTIMORE 8. Date of Birth7–25–1915 9. Birthplace (State or Foreign (Month, Day, Year) RUSSIA Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min. 1 🗆 M 2 🔀 Days 219928560 Months Hours **Director** 96 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD BALTIMORE BALTIMORE 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7920 SCOTTS LEVEL ROAD 21208 USA 12, Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed 3 Widowed 4 X Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) X-RAY TECHNICIAN MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be NUCHIM **GESIS** SHEVA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau VALENTINA SCHWARTZ / 12246 ROUNDWOOD RD.,#609 NIECE TIMONIUM, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
ARLINGTON CHIZUK
AMUNO CONG 1 🏋 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 01/20/2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate
Interval Between
Ogsetrand Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Strue Physician/ disease or condition Medical resulting in death) Due to (or as a consequen of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: been signed by the attendin should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death ☐ Yes 2 ☐ No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by arleis disease 2 No 1 🗌 Yes 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? director, page 2 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? Hospital Other: 1 🗌 Yes 2 🗆 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident М Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріете Defining injection. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RASTON 243 lyp ane 4 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		Ame	nd #12, per FD	ase Type or G923 State o	Print in TT Marylar	Black I	ndelible li artment of	n k. Ens Health	ure All Co and Menta	opies A al Hygie	Are Legib ne	le.
			State Registrar 1. Decedent's Name (First, Midd.)	le, Last)		Ce	rtificate of	Death		te of Death	. No. 20	2 0 3 2 5 3. Time of Death
	Physicia Medio Examir	cal	James Jackso		nber)	_	4b. City, Town,	or Location of	Jar	uary	18, 20.	
4	ŧ.		814 Castle Ro	oad T 6. Sex	7. Age (In yrs.	last hirthday)	Glen I		24 Hrs R Dot	e of Birth	Anne A	rundel
	Funeral Director		227-24-8053 Usual Residence of Decedent	1 M 2 F	85	Yrs.	Months Day			onth, Day, Ye	1926 W	Birthplace (State or Foreign Country). est Virginia
	tryland a-f show ied at	ctor	10a. State 10b. County Maryland Anne			ty, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🔯 No
	with the Ma 23a or 28a ist be notif	Funeral Director	10e. Street and Number 814 Castle Rd.	Arunder	016.	II DUIII	10f. Zip Code 21061				. Citizen of Wha	it Country?
36	after death	by	11. Marital Status 1 □ Never Married 2 🗷 Ma 3 □ Widowed 4 □ Divorce	Armed Formal Tried 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 🗌 No	' 73	Was Decedent of If Yes, specify Cu	ban, Mexicar	n, Puerto Rican, e	or No- etc.)	Black, V	American Indian, White, etc.
5-00	2 hours "natura dical E	Completed	15. Decede	Year or Dent's Education est grade completed,		16a. Dece	edent's Usual Occi	upation	t of working	16	SpecifyWh b. Kind of Busin	
21215-0036	within 73 giene. er than , the Me		Elementary/Seconday (0-12)	College (1		life. L	Navy -	d)	Convoluing	M	lilitary	
	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, James Arthur G	•					er's Name <i>(First,</i> Elizab		,	
Maryland	d 2 should alth and Math and Mark no. 27 is mare traumati		19a. Informant's Name/Relations Nellie Louise	ship (Type, Print)	Vife	1	ing Address (Stree	et and Numbe	er or Rural Route	Number, Cit	ty or Town, State	e, Zip Code)
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Specify)	State (cemetery, cre tro Cr	osition (Name of matory or other piematory,	Inc	Jan 20 2012	, 0	Catonsvi	y or Town, State
Ba	permi Depar Impor any ir		21. Sign Ture of the eral Service	Licensee		K 4	2. Name and Add irkley-R 21 Crain	ress of Facilit uddick Hwy.,	Funera S.E.,	l Home Glen B	P.A. Surnie,	MD 21061
	hy i i n Medical		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on a	ch line.	th. Do not en						Approximate Interval Between Onset and Death
90	executed an and rial-transit	dical Examiner	Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b	or as a conseq	ne 50	ipra Noc	lear	PAISY			5 years
. Box 68760	ath certificather attending for use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 N No 9 Unknown		Birth 2 D Fet nant at time of	aldeath 3	☐ Ectopic pregna☐ Other (specify)	ncy			23d. Date o Month	f delivery Day Year
ls, P.O.	uires that the des n signed by the a uld be detached i	हि	Part II. Other significant conditi	ons contributing to d	eath but not res	sulting in the	underlying cause	given in Part	1. 23			te to the cause of death?
Records,	The law requires cate has been sig page 2 should b	Completed								a. Was an autopsy performed Yes 2	d? prior	e autopsy findings available r to completion of cause of th?
of Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ※ No	Hospital:		1	0	her-	th (Check only or	ne)		
ι of V	ling Phy I. After this funeral d	ate: To	27. Manner of Death 1 Natural 5 Pendi 2 Accident Invest	28a. Date	Inpatient 2 of injury th, Day, Year)	28b. Time o Injury	f 28c. Inji	4 ∐ Nu uryat urk?		-	e 6 U Other (S	Specify)
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Certificate:	2 Accident Invest 3 Suicide 8 Could 4 Homicide determ	nined 28e. Place	of Injury - At ho		M 1 [Yes 2	28f. Loc	cation (Stree or Town, S		r Rural Route Number,
	To the Hospit within 24 hour To the Funera completed fille	Medical	(Check 2 Medical I only one) 3 A Certifying	g Nurse Practioner:	is of examinatio	n and/or inves	stigation, in my opia	nion, death oc	curred at the time	e, date and p	lace, and due to	the cause(s) and manner stated
	To Con		29b. Signature and title of certifie	ler cu	P		Print) Print C+	se number 8354	1	29d.	Date signed (M	onth, Day, Year)
			30. Name and address of person	who completed caus	e of death (Iten	n 23a) (Type,	Print) bint ct	lasa	dera,	no.	21122	
	Stat Registra		31. Date filed (Month, Day, Van	2 3 2012	egistry's Signa	lure	back	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh 9924 2-3-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year erry that Firein 6:5 Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death cent Social Security Number Heir- (- (1 Year | If Under 24 Hrs Days Hours | Min. If Under 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 539-28-4624 **Director** 1 Ø M 2 □ F 11-24-1933 WA 7 Usual Residence of Dece 8 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits notified 28a-f 1 ☐ Yes 2 X No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a 458 Chartley Park Road USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: (Caucasian) "natural" Completed 3 Divorced 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Machine Operator Tesoro Oil Campany traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental Fis marked of ပ James Daniel Hatfield Carmen Dohletron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hiz S. Amya/ WifeLuz Stella Amaya 458 Chartley Park Road, Reisterstown, MD 21136
of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Important: If it any injury or o once. 1 \square Burial 2 X Cremation 3 \square Removal from State cemetery, crematory or other place) Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 1-23-2012 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or compiler one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Acritonitis Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): death certificate be executed Cause (Disease or injury errestus 5 rame that initiated events resulting in death) Last Due to (or as a consequence of): physician ar s the burial-t Physician/Medical Box 68760 nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 1 Yes 2 9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 🗹 Probably 4 ☐ Unknown 1º0. (una Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an COFA has autopsy performed? pracanona Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} \) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending s after death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \square Homicide determined To the Hospital within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) January land derce 029085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JAN 2 3 2012 5300 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

P.0.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Mary		artment of F tificate of L			2012	01327		
	_		Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate of L	Jean	2. Date of Death	No. 2 U I Z	3. Time of Death		
	Physicia Medic		Stephen David Hendry					17, 2012	8:35 P M		
9-20	Examin		4a. Facility Name (if not institution, give street and number) Gilchrist Hospice		4b. City, Town, or	r Location of Death		4c. County of Death			
المحاليدية	Funeral	-	*	yrs. last birthday)	If Under 1 Year		8. Date of Birth		nplace (State or Foreign		
	Director		551-86-7532 1X M 2 🗆 F		Months Days	Hours Min.	(Month, Day, Yea Feb. 20,	ar) Cou	ntry)		
	nd how at	ž	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Loc	cation				10d. Inside City Limits		
	farylar 8a-f s tified	recto	MD Howard	Catonsvi					1 🗆 Yes 2 💢 No		
	a or 2 be no	iO le	10e. Street and Number		10f. Zip Code	~~	_	. Citizen of What Cou	intry?		
	tth witl ms 23 must	Funeral Director	7 Holmehurst Avenue 11 Marital Status 12. Was Decedent Ever	m 11 C 112 N	212			USA			
9	ter des or ite	by Fu	Armed Forces? 1 ☐ Never Married 2 🏋 Married 1 ☐ Yes 2 🛣 No			ispanic Origin? (Spec an, Mexican, Puerto F	lican, etc.)	14. Race - Amer Black, White			
21215-0036	ours af tural", al Exa	Completed by	3 Widowed 4 Divorced If Yes, Give Year or Dates.		Yes 2 No			Specify:			
-51-2	72 hc an "na Medic	mple	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give I	lent's Usual Occup kind of work done o O NOT use retired)	during most of workin	g 16k	b. Kind of Business/I	ndustry		
212	withir giene ner tha t, the		5+		Engin	eer	A	erospace			
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) James Davie Hendry			18. Mother's Name (First, Middle, Maiden Surname) Juanita Bussen					
aryl	hould Ind Me		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	t and Number or Rural Route Number, City or Town, State, Zip Code)					
Σ,	lealth a		Kathleen Hendry Wife			Avenue; Ca		.e, MD 212			
Baltimore,	age 1 a ent of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	0b. Place of Dispos tlantic	sition (Name of patory or other plac Crematory	1/19/		c. Location - City or T len Burnie			
altir	permit. Pa Departme Importan any injur,		21. Signature of Fineral Service Licensee				ling Asht	on Schwab	Witzke		
<u>B</u>	B m De		Mule fly St	116	30 Edmon	dson Aveni	ie: Caton	inc. svlle, MD	21228		
Н			23a. Pan 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final		r the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death		
ÇS.	Physician/ Medical		disease or condition resulting in death) a. Due to (or as a col		CER				MON745		
	Examiner	Ĺ	Sequentially list conditions, b.								
N	sit sd	Examiner	it any, leading to immediate Due to (or as a concause. Enter Underlying	isequence oij.							
J\$	xecute n and al-tran	Exar	Cause (Disease or injury that initiated events c. Due to (or as a corresulting in death) Last Due to (or as a corresulting in death)	nsequence of):			· · · · · · · · · · · · · · · · · · ·				
09	death certificate be executed re attending physician and ed for use as the burial-transit	dical	d								
687	rtificat ing ph e as tl	/Mec	IF FEMALE:								
Box (eath certifical attending ph I for use as ti	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pi	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of deli Month	very Day Year		
-	hat the dea ed by the a detached f	hysi	9 ☐ Unknown 9 ☐ Unknown								
, P.O.	gn Se		Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause giv	ven in Part I.		co use contribute to	the cause of death?		
ords	requires been signatures	Completed by					24a. Was an		opsy findings available		
3ec	The law ate has page 2	omo					autopsy performed 1 Yes 2	prior to co	ompletion of cause of		
tal	ysician: The is certificate director, pag	BeC	25. Was case referred to medical examiner?			ace of Death (Check	,	E NO 1 LOS			
f Vii	Physic this ce	은	Hospital:	2 ER/Outpatien		4 ☐ Nursing Hon		6 Other (Specif	Y) HOSPICE		
0 uc	nding ath. : After e funei	icate	1 Natural 5 Pending (Month, Day, Yea		28c. Injury work M 1 \square		8d. Describe how in	njury occurred			
Division of Vital Records,	or Atten after deat Director: I in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - building, etc. (Sp.		et, factory, office	2	8f. Location (Street City or Town, St	and Number or Rura	al Route Number,		
Ō	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my k	nowledge, death o	ccurred at the time	e, date and place, and			ted.		
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	(Check 2 Medical Examiner: On the basis of examinonly one) 3 Certifying Nurse Practitioner: To the best	nation and/or invest	igation, in my opinic	on, death occurred at t	he time, date and pl	ace, and due to the ca	ause(s) and manner stated.		
	To t with To t		29b. Signature and title of certifier	1 1	29c. License	number	-	Date signed (Month,			
	0,		30. Name and address of person who completed cause of death	(Item 23a) (Time P	rint)	04395	10	HIVWARY	18,2012		
	10		30. Name and address of person who completed cause of death DANIENE DOBERMAN, M.	0 633	6 CEDA	L LANE	comm	BIA, MO	21044		
	Stat	е	31. Date filed (Month, Day, Year) 32. References								
	Registra	1	'THN 2 3 2014 Plans	J 53. 14	Hat and	_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decement's Name (First, Middle, Last) 3. Time of Death **Physician** OU3AM ubba anuary 19 2012 icia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 2 🗆 F Hours 1 □ M 219-70-0204 53 Director Oct.25,1958 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD Baltimore 1 ☐ Yes 2 ☐ No Director r than "natural", or Items 23a or 28a-f s the Medical Examiner must be notifiled 10e. Street and Number 10f. Zin-Code 10g. Citizen of What Country? 4203 E. Lombard St. 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify If Yes Give Specify: Black 2 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Dietary Aide Bayview Medical Cente 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland æ Curtis Bacot'e Molly Hubbard ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Archer Jr (son) 2718 Orleans St. Balto, Md. 21224 or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cemetery Jan.26,2012 Balto, Md. 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home tore of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respin shock, or heart failure. List only one cause on each line. 21213 pproximate Balto Md. immediate Cause (Final Cardiovascular disease **Physician** Hypertensive disease or condition resulting in death) /Medical Due (or as a consequence of) Examiner Se pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence ot) The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 2 No ed by the at detached f 9 Unknown 9 WUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 🗌 No 1 Yes 2 No. 1 Tes certificate or Attending Physician: 25. Was case referred to medical director. 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ပ္ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🕍 Natural death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: Af oletely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 1 🔀 Certifying Physician: 🍞 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only completely within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8258229 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Toff mann Round 4940 Eastern Avenue, Baltimore, MD, 21224 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Marylan		artment of <i>tificate of</i>			lental Hy	giene Bea No	2012	01329
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ath		3. Time of Death
	Physicia Medic		BARBARA	EVANS		HOLMES			JANUAR		1 7 2012	10:20 A M
.)	Examin	er	4a. Facility Name (if not institution, give str 10990 WHARTON DE			4b. City, Town, UPPER					. County of Death	
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year Months Days	r If Unc	der 24 Hrs.	8. Date of Birt	h	9. Birtl	nplace (State or Foreign
	Director		228-62-3009	M 2 ₹ F 66	Yrs.	Months Day	Hours	5 IVIII1.	MARCH Day	13"/1	1945 VIR	GINIA
	and show lat	ō	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Maryla 28a-f	Director	MD PRINCE GEO	ORGE'S UP	PER MA	RLBORO						Yes 2 No
	th the		10e. Street and Number			10f. Zip Code					tizen of What Cou	untry?
	ath wi	Funeral	10990 WHARTON DR	[VE 2. Was Decedent Ever in U.S	S. 13. V	2077		Origin? (Spec	cify Yes or No-	USA	14. Race - Amer	ican Indian.
900	rs after de ural", or ite Examiner	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.		f Yes, specify Cu	ban, Mexic	can, Puerto F	Rican, etc.)		Black, White	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	completed) College (1-4 or 5+)	(Give life. D	dent's Usual Occi kind of work don O NOT use retire	e during m d)		ng		Kind of Business I	ndustry
d 2	led wi Hygie other ent, tl	Be	17. Father's Name (First, Middle, Last)	5+	DIKE	CTOR OF			(First, Middle,			
/lan	d be fi Mental arked atic ev	욘	CLINTON EVANS				E	BEATRI	CE R	AWL	ES	
	id 2 should leath and Me n 27 is marl er traumati		19a. Informant's Name/Relationship (Type VALERIE HOLMES/I								r Town, State, Zip ORO , MARY	Code) LAND 20774
Baltimore,	Page 1 and nent of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, crer	sition (Name of natory or other p		1	Date		ocation - City or	
altin	# 한 분 중		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	J ROO	OSEVEL 22	T MEMOR] Name and Add	ress of Fa	Ķ 2/6/ cility J.	B. JEN	KIN	FOLK, VII FUNERA	L HOME, INC.
ñ	Depar Impor any ir	1	Myskeine									AND 20785
-	hysician/	0.0	23a. Part 1. Enter the disease, or complic shock, or beart failule. List only one Immediate Cause (Final disease or condition	ations that caused the deat cause on each line. CARDIOMYOPA'		er the mode of dy	ing, such	as cardiac o	r respiratory an	rest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):							
	n =	niner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):							
320	icate be executed physician and s the burial-transit	Examine	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):							
8	e be e iysiciar ie buriż	edical	d.									
	ertificat ling ph	/Mec	IF FEMALE:	c. If yes, outcome of pregna	IDCV.							
. Box 68760	res that the death certific signed by the attending I d be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 Live Birth 2 Feta 4 Pregnant at time of c	al death 3	Ectopic pregna Other (specify)					23d. Date of deli Month	Day Year
s, P.O	ires that the signed by do be detailed	þ	Part II. Other significant conditions cont	ributing to death but not res	sulting in the u	ınderlying cause	given in Pa	art I.				the cause of death?
ecord	ie law require e has been si ige 2 should	Completed								osy ormed?	prior to death?	opsy findings available completion of cause of
al B	ian: Tr	Be C	25. Was case referred to medical examiner?			26.	Place of D	Death (Check	1 \(\text{Yes} \)	2 l <u>sy</u> N	ioj i li tes	2 No
Zit.	hysici this ce	유	1 Yes 2 XNo	spital:		nt 3 🗆 DOA					6 Other (Speci	fy)
n ol	iding F th. After i	cate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	we	iury at ork? □ Yes 2	- 1	28d. Describe h	now inju	ry occurred	
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completed filled in by the funeral director, page 2 should be detached for use as	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify				-	28f. Location (S City or Tox		nd Number or Rur e)	al Route Number,
_	he Hospit in 24 hour he Funera ipleted fille	Medical	(Check 2 Medical Examine	ian: To the best of my know r: On the basis of examination Practioner: To the best of m	n and/or inves	tigation, in my opi	inion, death	h occurred at	the time, date a	and place	e, and due to the o	ause(s) and manner stated.
	Not To t		29b. Signature and title of certifier	•			nse numbe			29d. Da	ate signed (Month	, Day, Year)
J			30. Name and address of person who con	muleted cause of death (Item	1 23al (Type 1)3945	1		J	IANUARY .	19, 2011
	//		MARK HOFMEYER M.	D. 110 IRVIN	G STRE	ET N.W.	WASH	INGTO	N DC 20	010		
	Star Registra	te ar	31. Date filed (Month, Day, Year) 2 3 2012	32. Registrar's Sign	ture	les						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

iam Edward		1- For State	ate of Maryla		artment of			Menta	al Hyg		2 C	12	0133
Physicia dical Examí	an/	1. Decedent's Name (First, Middle		11 Tr	WW 100					Date of Deat Month January 9,	h Dav Year		3. Time of Death 1924 hrs
arour Exam.		William Ed	n, give street and nun	nber)	T.	4b. City, To	own, or L	ocation of		January 5,	4c. County o		
		Civista Medical Cente	r			LaPlat		Len	2 m . L		St. Mary		(0)
Funeral Director		5. Social Security Number 217–64–4532	6. Sex	7. Age (In yrs. I	ast birthday) 56 Yrs	Months		If Under: Hours			h(мм/DD/YYYY) , 1955	Foreign	
		Usual Residence of Decedent	122 141 2 1		113	<u> </u>		<u></u>		<u> </u>		L	
w any		10a. State 10b. County		10c. City,	Town or Locat							- 1	10d. Inside City Limits 1 X Yes 2 No
yland P-f sho	tor	Maryland Fre	ederick			Thu 10f. Zip (urmoi	nt	-		og. Citizen of Wh		
ith the Maryland 23a or 28a-f show	Director	4 Sandy Spring	Ct., Apt	. 3		1011 22.10		21788			•	5.A.	
n with t	uneral	11. Marital Status	12. Was Dece	dent Ever in U		s Deceden es, specify				ify Yes or No-	14. Race White		an Indian, 8lack,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ш	1 Never Married 2 Ma 3 Widowed 4 Div	1 Yes	2 X No		Yes 2			donto i tito	San, Sto. /	Specify:		rk
ours aft tural"	d by	6 15 December 5 duration (Specific grade completed) 150 December 1 liquid Councilion (Give kind of work date)								16b. Kind of 8us			
n 72 hc	ompleted	Elementary/Secondary (0-12)	College (1-	4 ог 5+)					se retired)	transr	~rt:	ation
5-0036 iled within 7. Hygiene. I other than the Medical	шо	12 17. Father's Name (First, Middle,	4 truck driver tran						_	01 6			
215 be filed ntal Hy rked of	William E. Hill Sr. Harriet Frisby												
21 should be nd Mer is mar	2	19a. Informant's Name/Relationship (Type, Print) Harriet Hill / mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 500 Main St., #106 New Windsor, M											
and 2 sho fealth and tem 27 is traumati		20a, Method of Disposition	lother		Place of Dispos	ition (Name				ate WI	20c. Location -		
Baltimore, oernit. Pages I an Department of Hea Important: If iter njury or other tr.		1 X Burial 2 Cremation			crematory or oth James		terv		1/17	/2012	New Wi	indsc	or, MD
altin mit. P partme ports ury or		4 Donation 5 Other Sp 21 Signature of Funeral Service		10.			_				uneral E	l ome	
		23a. Part I. Enter the disease, or	O. Xar	Ser		E. B					Bridge, N		1791 Approximate Interval
Physician /Medical		failure. List only one cause							diac or re	spiratory arre	est, shock, of fiea	"	8etween Onset and Death
<i>E</i> xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a			Ovascan	ui Di30	.430					
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence o	nf):							-+	
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated vevents resulting in death) Last Due to (or as a consequence of):										-	
cuted nd transit		events resulting in death) Last	d										
be executed be executed sician and urial - transi	dical	UNPENDED	AMENDED										
876(tificate ng phys as the b	ian/Me	IF FEMALE: 23b. Was decedent pregnant in th		utcome of preg th		tal death	3	Ectopic p	pregnancy	y	23d. Date of o Month	delivery Dag	y Year
P.O. Box 68760, st that death certificate be executed gred by the attending physician and betached for use as the burial - transit	Sic	past 12 months?	1 ' -	int at time of de	eath 5 Ot	her (Speci	fy)						
D. B t the de by the ached f	Phy	Part II. Other significant conditi	a Olikilot		esulting in the u	inderlying o	cause giv	en in Part	I.	23e. Did to	bacco use contrib	oute to th	e cause of death?
n of Vital Records, P.O. fing Physician: The law requires that the After this certificate has been signed by huneral director, page 2 should be detach	d b	Hypercholesterolemia	1							1 ✓ Yes	2 No 3	Probat	bly 4 Unknown
ords w requ	Completed									24a. Was a autop	sy pi	rior to cor	psy findings available mpletion of cause of
Rec The la icate h	S									1 Yes		eath? Yes	2 No
ician:	B	25. Was case referred to medical examiner?	Hospital: 1	patient 2	ER/Outpatient		Iñ	of Death (C			Residence 6	Other:	
n of Vital Records, ding Physician: The law require After this certificate has been si funeral director, page 2 should the	<u>ان</u>	1 Yes 2 No 27. Manner of Death	28a. Date o		28b. Time of I			at Work?			now injury occurre		
tteodin death. ctor: /	cation	1 ✓ Natural 5 Pend 2 Accident Inves	ing tigation					es 2 N					
Division pital or Atteodio ours after death. teral Director: A	ertific	deter	not be mined 28e. Place (Specify)	of Injury - At h	ome, farm, stree	et, factory,	office bui	ilding, etc.	28	f. Location (S or Town, S		r or Rura	I Route Number, City
Hospi 24 hou Funer tely fil	edical Ce	29a. Certifier 1 Certifying Prone) Certifying Prone)	nysician: To the best	of my knowled	ge, death occur	red at the t	ime, date	e and place	e, and du	e to the cause	e(s) and manner	as stated	i.
To the within To the comple	Medi	29b. Signature and title of certifie	and manner sta	ated.	4		License		, (29d. Date signe		
am		(, la ,	11	1	1	7	O.C.M	I.E.			January 10,	2012	
A 24,		30. Name and address of person		·		- (0:			D 01000			
	o i c	Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year)	Assistant Medica	al Examiner gistrar's Signati		altimore	Stree	t, Baltim	nore, M	D,21223			
St Regist		JAN 2 3 2012	Beneva		barres								

DHMH 17 Rev 1/2001

ORIGINAL

				Plea	se Ty	pe or l	Print	in Bl	ack In	delibl	e Ink	Ensur	e All (Copies	s Are	Legibl	e.		
			For State		S	State of	f Mary	yland				lealth ar	nd Mei	ntal Hy	/giene	20	12	Ω	133
		-	1 - State Registrar 1. Decedent's Nam	- (Final 881-4-4)	- 14)				Ce	rtitica	te ot	Death		Date of De	Reg. No	. <u>4</u> U	12	U	100
	Physici	an	1. Decedent's Nam	e (Filst, Wildel	e, Last)	14	1-N/	SES	_					Month	Da		ear .		e of Death
_	/Medic		4a. Facility Name (I	If not institution	a give stre	et and num		26-2	>	4b. City	/. Town. o	r Location of [anuar	THE .	3, 201 County of		2:4	45 P. ^M
	Examir	ier	Brinton W				,	nter				sville				,	rol	7	
-	Funeral		5. Social Security N		6. Sex				st birthday)	1	er 1 Year	If Under 24	Hrs. 8.	Date of Bi (Month, D	rth av Voar	9		lace (Sta	te or Foreign
2/4	Director		577-05-86		YLAM.	2□ F		9.	4 Yrs.	Worters	Days	Tiodio	M	ay 1,	191	.7 V		inia	
	and		Usual Residence of 10a. State	10b. County			10	Oc. City,	Town or Lo	cation							1	Od. Inside	e City Limits
	Mary f sho	tor	MD	Car	roll			W	estmi	nste	r							1 🗆 Y	res XXNo
	r 28a	Director	10e. Street and Nu								ip Code	<u></u>			10g. Çi	tizen of Wh	at Cour	itry?	
	th wit 23a o 1st be		828 Lucak	augh M	ill F	Road					2115	57				Jnited of Ame			
	r dea	Funeral	11. Marital Status	3737		Was Dece Armed For 1 ☐ Yes	dent Eve	er in U.S.	13.	Was Dec	edent of F	lispanic Origin an, Mexican, F	n? (Specif	y Yes or Nan, etc.)	0-	14. Race - Black,	Americ White,		,
36	s afte	by Fi	1 ☐ Never Marr 3 ☐ Widowed		ried	1 ☐ Yes If Yes, Giv Year or Da	re			1 ☐ Yes	XX No	Specify:				Specify:	Whit	te	
21215-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dieal Examiner must be notified at	ed k		15. Deceder	t's Educati	ion	ates.		16a. Dece	dent's Us	ual Occup	ation			16b. K	(ind of Busin			-
215	within 72 iene. than "n i t he Medi	Completed	(Spec	cify only highe	st grade co	ompleted) College (1	-4or 5+)	-1	(Give life.	kind of w DO NOT	ork done use retire	during most o	f working		Ť			•	
21	ed wit	Som	12th						Payr	oll d	and I	ccounting Federal 18. Mother's Name (First. Middle, Maiden Surname						verni	ment_
pu	be filed tal Hygi d other event, t	Be	17. Father's Name	, , , ,									,		,	n Surname)			
Zla	should be ind Mental marked c	P	Charles E			D-/1)		Т	405 34-11		(0)	Lilli				- a			
<u>⊠</u>	d2sh than than 7 Isr traur		Charles H								-	and Number of Church							5.0
ē,	s 1 and f Health fem 27 other tr		20a. Method of Disp	position	- ,			20b. Pla	ce of Disponetery, cre				Date	9		ocation - Ci			
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		1 ☐ Burial 2 4 ☐ Donation			oval from S	State	All	Fait	hs C apel	remat	Cory J	Tan. 2012		Man	chest	er,	Mar	vland
alti	permit. Departm Importa any Inju once.		21. Signature of Fu	inery Garve	Licensee	1-/	/				and Addre	ss of Facility	Eckh	ardt					
<u> </u>	S II D D	2 1	Com	OV	MUU	m.	•		3	296 (Charn	nil Dr.	, Ma	nches	ter,	MD 2	.110	2	
н			s or hea	he disease, or art failure. List	complicat only one o	ions u hat ca cause on ea	aused the ach line.	e death.	Do not en	ter the mo	ode of dyir	ng, such as ca	ardiac or re	espiratory a	arrest,				mate Between nd Death
(I)	Physician		Imme e Cause disease or condition resulting in death)	(Final on	a		TWE	edu	erua									Onsera	ild Death
	/Medical Examiner		rooming in down,			Due to (or as a co	onseque	nce of):										
	iek o	er	Sequentially list co if any, leading to in cause. Enter Under Jause (Disease of	nditions, nmediate	b	Due to (or as a co	onseque	nce of):								_		
	executed in and iaf-transit	Examiner	Cause. Enter Under Cause (Disease of that initiated events	erlying injury s	G.												- 4		
60,	e exe lan ar uriaf-tu		resulting in death)	Last		Due to (or as a co	onseque	nce of):										
876	eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical			d												_		
Box 687	certific ding p	/Me	IF FEMALE:		230	If yes, outo	come of r	oregnand	°V							001.5	- 1		
Bo	atten for us	cian	in the past 12	months?	200.	1□Live bi	irth 2	Fetal d	léath 3[Ectopic Other (pregnanc	У			Ì	23d. Date Montl		ery Day	Year
P.O.	t the c by the ached	hysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown			9□Unkno					. ,,								
S, T	Attending Physiclan: The law requires that the death certificate roteath. crost. After this certificate has been signed by the attending physy the funeral director, page 2 should be detached for use as the	by P	Part II. Other signi	// .			ath but n	ot result	ing in the u	nderlying	cause giv	en in Part I.		23e. Did	tobacco	use contrib	ute to th	ne cause	of death?
Records,	equire				MI	·				7	,		_	1 🗆	Yes 2	2 □ No 3	☐ Prot	ably 4	□Unknown
ec	law ras be	Completed		IMUR	, 7	RAN	SVO	RSC	5 (OLC			_ "		psy				ngs available of cause of
	: The cate !	Con								_				perf 1∐ Yes	formed? 2 N	o de	ath?]Yes	2 1 No	-
Vita	siclar certif rector	Be	25. Was case refer examiner? 1 ☐ Yes 2 ☐		Hos	pital: ,			7/0		Oth	26. Place of							
o	g Physer this eral di	2	27. Manner of Deat			28a. Date o	of Injury	2	R/Outpatier 8b. Time o		28c. Injui Woi	4 Wursi				6 Other		<i>y)</i>	
on	ath. r: Afte e fun	atio	1 ☑ Natural 2 ☐ Accident	5 ☐ Pendir investi		(Monti	h, Day Ye	ear)	Injury	М		rk? Yes 2∐No							
Division or	r Atte er de irecto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could determ	not be ined	28e. Place buildir	of injury	- At hom Specify)	e, farm, sti	eet, facto	ry, office		28f	Location City or To	(Street a	nd Number	or Rura	al Route I	Vumber,
	vital o			7	- 1								1						
	Hosp 24 hou Fune stely fi	Medical	29a. Certifier (Check only one)	2 Medical	ng Physici Examiner	an: To the On the ba	asis of ex	aminatio	edge, deat on and/or in	h occurre vestigation	d at the ti on, in my o	me, date and popinion, death	place, and occurred	due to the at the time	e cause(s e, date ar	s) and mani nd place, an	ner as s id due t	tated. o the cau	se(s)
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Mec	29b. Signature and	title of certific	7	and mark	isi siaie0			2	9c. Licens	e number			29d. Da	ate signed (Month,	Day, Yea	ur)
	->-0		> Ka	telle	Tu						2-	20806	2		/	/ /	0/2		
~	JON		30. Name and addr	ress of person		leted cause	e of death	h (Item 2	(3a) (Type,	Print)		2080G		7 /	0 1	, ,			
	U		THTRIC		NES	LD	11	4	1 /	uess	(Pa)	ter Dr	-	Kolst	Ref Te	n, d	0	210	36
	Sta Registr		31. Date filed (Mon	23201	2	32. Re	egistrar'	Signati	GI Ka	2									
	negisti	uı			1		0.5	. 5											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6.07 PM 2012 Jan 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard Birthplace (State or Foreign Country) Social Security Number Sex 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** (Month, Dav. Year) Months Hours Director 212-20-8879 1**X**XM 2 □ F 87 1924 26, July MD Usual Residence of Decede 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 Yes 2XXNo MD Howard Laurel 10f. Zip Code 10e. Street and Number 9 10g. Citizen of What Country? ber 23a Funeral 9002 Dumhart Road must 20723 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner med Forces?

Yes 2 \(\sigma\) No Black, White, etc. ò þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ament of Health and Mental Hygiene.

The 1 fitem 27 is marked other than "natural", or sure if item 27 is marked other than "natural", or uny or other traumatic event, the Medical Examin uny or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 ₩Widowed 4 Divorced Completed White 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Stationary Engineer Glass Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Robert Huber Margaret Marie Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9846 Robinson Blvd., Laurel, MD 20723 Robin Marton/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State January 2012 23 4 Donation 5 Other (Specify) Meadowridge Mem.Park Dorsey, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01053 313 Talbott Ave., Laurel, MD 20707 Reaft 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ge , 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 26. Place of Death (Check only one) 2

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After e Funeral Director: A e Funeral Director: A bletely filled in by the f

25. Was case referred to medical examiner?

1 Yes 2 No Other: 1 Pinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 2 🗌 No Investigation Accident 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 2

To the I

complex

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Columbia 21044

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

00072376

Jan

2012

State Registrar

Certificate:

Medical

(Check

only one

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygiene
			■ Registrar CE	rtificate of Death	Reg. No. 211 2 11 3 3 3
	Physicia		1. Decedent's Name <i>(First, Middle, Last)</i> Donald Blake Jarvis		Jan. Pay 2012 3. Time of Death 5:14 pm M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
A	Lxamiii		Dove House	Westminster	Carrol1
	Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Foreign
	Director		213-42-2978 1 😾 M 2 🗆 F 66 Yrs.	Months Days Hours Min.	Apr. 21, 1945 Mary Land
7	t ow	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	egation	10d. Inside City Limits
200	ieda	cto			1 ☐ Yes 2 ☒ No
N O	r 28a notif	Dire	MD Carroll Har	mpstead 10f. Zip Code	10g. Citizen of What Country?
ŧ	23a o st be	Funeral Director	4007 Meadow Lane	21074	U.S.A.
t to	ems ;	nne		Was Decedent of Hispanic Origin? (Spe	
် ငေ	or it		Armed Forces? 1 □ Never Married 2 □ Married 1 🛣 Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Black, White, etc.
033	ıral", Exa	ed	3	1 ☐ Yes 2X No Specify:	Specify: White
2- 2-	"nati	plei	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	16b. Kind of Business Industry
121 F	than	Completed by	Elementary/Seconday (0-12) Gollege (1-4 or 5+)	OO NOT use retired) Plumber	Plumbing
N F	Hygie other	Be	8 17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)
Maryland 21215-0036	ental ked c c eve	욘	Russell Jarvis	Paul	
בובי	sional and Me is mar raumati				al Route Number, City or Town, State, Zip Code)
Š	サンサ		Eric Jarvis Son 559	9 Hunting Horn Dri	ive Ellicott City, MD 21043
j.	or other	1	20a. Method of Disposition 20b. Place of Disposition	osition (Name of matory or other place)	Date 20c. Location - City or Town, State
mor	nent c		I ZE Duliai Z _ Cielliation 3 _ Nemoval nom State	Cemetery 1/21	./12 Woodlawn Cemetery
Baltimore,	Department Important: If any injury or once.		21. Signature di Funeral Service Licensee 2	Name and Address of Facility	1824 Reisterstown Road
m 8	70 E # 9	1	J Wayne Osterling E		Reisterstown, MD 21136
			23a, P 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest, Approximate Interval Between
-P1	nysician/	y y	mmediate Cause (Final lease or condition a. a.	ic becar	Onset and Death
A.	Medical xaminer		Due to (or as a consequence of):	V	
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
. 0	asit .	min	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (u)sease or Injury		
V §	al-trar	Examine	that initiated events resulting in death) Last Due to (or as a consequence of):		
So y y y y y y y y y y y y y y y y y y y	hysician and the burial-transit	dical	L _d		
376 ficate	g phy as the	Med	IF FEMALE:		
K 687(endin	an/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy	23d. Date of delivery
Box	re att	Physician/Me		Other (specify)	Month Day Year
o ဦ	d by ti	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
	been signed by the attending pt should be detached for use as th	d by	,	, 5	1 Yes 2 No 3 Probably 4 Unknown
cords,	peen	ete			24a, Was an 24b. Were autopsy findings available
Division of Vital Records,	as 2	Completed			autopsy prior to completion of cause of death?
*	certificate has rector, page 2		25. Was case referred to medical	26. Place of Death (Chec	1 Yes 2 No 1 Yes 2 No
Vita	s cerl	To Be	examiner? 1	Other:	ome 5 Residence 6 Other (Specify) Hospice
01	ter thi		27. Mann of Death 1 Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) injury		28d. Describe how injury occurred
ion	eath. or: At	iţica	2 Accident Investigation	M 1 Tyes 2 No	
VISI	fter d lirect n by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	 Location (Street and Number or Rural Route Number, City or Town, State)
	within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, an	and due to the cause(s) and manner as stated
HOS	24 h	Medical		stigation, in my opinion, death occurred a	t the time, date and place, and due to the cause(s) and manner stated
To the	within To the comp	2	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			Hemmo Kunlar MD	W 35 39 8	01-18-12
	lot)		30. Name and address of person who completed cause of peath (Item 23a) (Type,		110 + + 110 0007
	w .		Havio Kruter, M.D. 55	S. Center St.	Westminster MD 21157
	Star Registra		31. Date filed (Month, Day, Year) JAN 2 3 2012 A Registrar's Signature 32. Registrar's Signature	1	
	region	<11°	WHITH O COLL COMPANY P. T.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ James James 2012 2:29 A January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1137 St. Stephens Church Road Crownsville Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Months Hours **Director** 216-38-6400 1 🏋 M 2 🗆 F 70 Yrs March 18,1941 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 1 Yes 2 X No Maryland Crownsville Anne Arundel ä 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21032 1137 St. Stephens Church Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 0 1 X Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r United "States College (1-4 or 5+) Elementary/Secondary (0-12) National Security 12 Government Employee 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Davis Atkinson John Harris James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 si it of Health a If item 27 i 1137 St. Stephens Church Road, Crownsville, MD Alma Catherine Henckel/Partner Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Meadowridge Memorial Park 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Page 1 Department of Important: If it any injury or c January 20, 2012 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 Will Esone **7**M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician Tears disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) If any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-trans and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) 4 Pregnant : 9 Unknown Pregnant at time of death 1 Yes 2 No be detached signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 124 hours after death. • Funeral Director: After this certificate has b autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 HNO မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the I within 2 only one) 29b. Signature and title of ce 29c. License number 16, 7012 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ClenBune and 2005, W filed (Month, Day, Year, 32. Registrar's Signature **JAN 23** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name, (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner turecoure 7014 Birthplace (State or Foreig Country) 6. Sex last birthday) 5. Social Security Number 7. Age (/h.y.s. Funeral Months Davs Hours MD 1 □ M 2√2 F 85 Director 214-26-9177 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 28a-f shov ral", or items 23a or 28a-f shov Examinar must be notified at 1 Yes 2 No Director Baltimore n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3700 Gelston Drive 21229 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No African-American Specify If Yes, Give Year or Dates: <u>≽</u> 3 Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within, in and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Bercon Plastics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Fleet Hilda Chase t and 2 should b Health and Ment tem 27 is marked ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn I. McFadden/ Daughter 3600 W. Franklin Street, Apt 4A, Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 permit. Pages Department of Important: If its any Injury or o 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 1-25-2012 Crownsville Veterans Crownsville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature Fineral Saviça Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARCINOMA Immediate Cause (Final LUNG INRAMIN METASTATIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) been signed by the should be detached P.O. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Tyes 2 No 3 Probably 4 Unknown Completed HYPENTENDIN 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐Yes 2 ☑No 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28b Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatu f and title of certifier 29c. License number ASTENDING 00056948 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILKERS AVE # 204 BATIMONE MD 2/225

Registrar DHMH 17 Rev 1/2001

State

JANES 31. Date filed (Month, Day, 3455

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JÄNÜARY 20 2012 al KOTHARI JAYA MOOSPO Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY 8209 GAINSBOROUGH WEST POTOMAC Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** Days 1 🗆 M 2 🏝 Months Hours SEPT. Day 17 ar) 1918 INDIA 213-02-8552 93 Director Usual Residence of Decedent 28a-f show 10a. State 10h Count death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N.T MORRIS CEDAR KNOLLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 91 POPLAR DRIVE 07927 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 24 No Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 INDIAN 1 Yes 2 No Specify "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 nd Mental Hygiene. $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12TH \end{array}$ College (1-4 or 5+) HOMEMAKER PRIVATE permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည .TATASHANKAR SHAH MANTBEN MEHTA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HIMANSHU KOTHARI/SON POPLAR DRIVE CEDAR KNOLLS, NEW JERSEY 07927 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State -21-17 RIVERDALE CREMATORY RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funteral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year bed 1 signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24a. Was an Were autopsy findings available prior to completion of cause of cate has t autopsy perform death? certificate 2 No 2X N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) P Son In-law 1 X Yes 2 □ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27, Manner of Death 1 Natural Certificate: 28h. Time of Injury at 28d. Describe how injury occurred 5 Pending 1 Yes Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 1, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific END DIME

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Please T	ype or Print in AMEND, ITEM#	Black Ir	delible Inl	Ensure /	Vantal Hy	s Are Lec	gible.	
			For State Registrar	ype or Print in AMEND ITEM# State of Marylar AMEND ITEM#	5perFH, Cer	G928,6/I tificate of I	5/2012, ws Death	S	Reg. No. 2 0	112	01337
	Physicia		1. Decedent's Name (First, Middle, Last)	Roland L	ocklear			2. Date of De Month	Day	Year	3. Time of Death
my	Medic Examin		4a. Facility Name (if not institution, give str	eet and number)		4b. City, Town, or	Location of Death	7		ty of Death	<u> </u>
-	Funeral		ZIJ JU JZUT	AVENUE 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird		9. Birthp	elace (State or Foreign
E	Director s		Usual Residence of Decedent	M 2 🗆 F	68 Yrs.			,	-1943		MD
	aryland a-f sho fied at	Director	10a. State 10b. County		ity, Town or Loc					11	0d. Inside City Limits 1 Yes 2 □ No
	h the M. a or 28 be noti	al Dir	10e. Street and Number	-		10f. Zip Code			10g. Citizen of		try?
	eath wit ems 23 er must	Funeral		AVENUE 2. Was Decedent Ever in U	.S. 13. V	212 Vas Decedent of H	ispanic Origin? (Spe	ecify Yes or No-	U S /	4 ace - America	an Indian,
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatly and Mental Hygiene. Important: I file of 71 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🌠 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		f Yes, specify Cuba ☐ Yes 2 ☑ No	n, Mexican, Puerto Specify:	Rican, etc.)		ack, White, e	
15-0	72 hour r "natur ledical	Completed	15. Decedent's Educ (Specify only highest grade		(Give I	lent's Usual Occup kind of work done of O NOT use retired)	ation during most of work	ing	16b. Kind of E		1.
212	within /giene. ner thai t, the N		Elementary/Secondary (0-12)	College (1-4 or 5+)		PECTOR				MORE	RITY RITY
land	be filed ental H) ked ott ic even	To Be	17. Father's Name (First, Middle, Last) CHARLES V. LOCKL	EAR, SR.			18. Mother's Nam MARY			ne)	
Baltimore, Maryland 21215-0036	should and M is mai raumat	9	19a Informant's Name/Relationship (Type	Print)	19b. Mailir		and Number or Run	al Route Numbe	er, City or Town,		
re, N	1 and 2 of Health item 2; other t		TONY VARGAS LOCK 20a. Method of Disposition			sition (Name of	AVE . Ax	Date	20c. Location	- City or To	wn. State
timo	t. Page tment c rtant: If rjury or		1 M Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ALP Ho	NS 0'S CEMI	FRRY /2	8/2012	BANTI	MOR	E, MD m Sers PA
Bal	permi Depar Impor any ir	S	21, Signature of Funeral Service Licensee	01553	4	Name and Address 905 York	ss of Facility VA CK ROAD	· BALT	D, MO.	2121	2
	h, i ian/		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused the dea cause on each line. Biadder (1		er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as a consec						\neg	
W	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):						
Bu.	executed an and irial-transit	Exar	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):		<u></u>		<u> </u>		
09/	ate be physicia the bu	edica	d.								
Box 68760	th certific ttending or use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregn	tal death 3	Ectopic pregnanc	çy			Date of delive	ery Day Year
). Bo	the dea by the a ached f	hysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5 L	Other (specify)					
ls, P.0	uires that n signed l uld be del	by	Part II. Other significant conditions conti	ributing to death but not re	sulting in the u	nderlying cause gi	ven in Part I.				ne cause of death?
Division of Vital Records, P.O.	of the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director, After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Completed						24a. Was auto perfo 1 Yes	psy ormed2		psy findings available mpletion of cause of
ital	certifica	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	spital:		_ Oth	ace of Death (Chec	k only one)			
of <	ung Physician: After this certific funeral director,	ate: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	∠ ER/Outpatier ∠ 28b. Time of injury	at 3 ☐ DOA 28c. Injur work	4 ∐ Nursing H y at ;?		dence 6 🗌 Otl now injury occur		
ision	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral preserves.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h			Yes 2 No	28f. Location (Street and Numi	ber or Rural	Route Number,
i D	spital or spital or cours affineral Di		29a. Certifier 1 Certifying Physici	an: To the best of my know	wledge, death o	occurred at the time	e, date and place, a	and due to the c	ause(s) and mar	nner as stat	ed.
	the Ho thin 24 the Fu	Medical	only one) 3 Certifying Nurse I	: On the basis of examination of the best of	on and/or invest my knowledge,	tigation, in my opinion death occurred at 29c. License	the time, date and pl	at the time, date a lace, and due to	and place, and d the cause(s) and 29d. Date sign	manner as s	stated.
	× • • • • • • • • • • • • • • • • • • •		29b. Signature and title of certifier MS Lyyy M	M.P.		00	057465		1/19/		
	10		30. Name and address of person who com N.S. LAYAPACH, M.D.	npleted cause of death (Ite ないないないないないないないないない。 ないないないないないないないないない。		Print) 3 3a(4	inore	WD S	1209	•	
İ	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	hales					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Linton 2012 12:45 PM Thelma Marie January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 607 S. Main St. Frederick Woodshoro Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days Hours Mir **Director** 1 □ M 2 🕌 F 215-64-0546 Sep. 1, Maryland 62 1949 28a-f show 10a State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14720 Albert Staub Rd., Apt. 6 21788 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 ind Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11 housekeeper restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Francis Albert Bowers Goldie Virginia Anderson Department of Health and Mi Important: If item 27 is mark any injury or others 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jones/ sister 2630 Hobbs Rd. Glenwood, MD 21738 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 1/16/2012 Prospect Cemetery 4 ☐ Donation 5 ☐ Other (Specify) nr. Mt. Airy, MD Signature of Fundamental Service License 22. Name and Address of Facility Hartzler Funeral Home attaine (11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Consumy Physician AVITER MITHERW >c Lerws1 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 use a 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an or Attending Physician: The law has autopsy within 24 hours after death.

To the Funeral Director: After this certificate Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) residence 2 X No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate; 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDERICK Mn 2170 814 Toll House

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Darren D Lattiinore	1	- For State	ate of Maryla		artment o			Mental H	ygiene	Reg. No.	201	2 0133
Physician Medical Examine	1	egistrar I. Decedent's Name (First, Middl DARREN	e,Last)	Τ./	ATTIMORE	7			2. Date of De Month		Year	3. Time of Death 0256 hrs
		Aa. Facility Name (if not institution Prince George's Hosp	n, give street and nu					ocation of Death		4c. Cou	nty of Dea	
Funeral Director	5	5. Social Security Number 577-17-2642	6. Se x	7. Age (In yrs. 23	last birthday) Yrs	If Under	1 Year	If Under 24Hrs Hours Mir			YYY) 9. B	irthplace (State or igrWASHINGTON country)
ом япу	-	Jsual Residence of Decedent 0a. State 10b. County		10c. City	, Town or Locat	ion						10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f show tified at once. Director	1	DC Oe. Street and Number			JASHINGI	10f. Zip (10g. Citizen o	f What Co	21
er death with , or items 23 r must be no		137 RIDGE ROA 1. Marital Status 1 X Never Married 2 Ma 3 Widowed 4 Div	12. Was Dec	2 X No		s Deceden	Cuban, N	anic Origin? (S Mexican, Puerto specify:			Vhite, etc.	erican Indian, Black, BLACK
5-0036 ed within 72 hours afti stygiene. other than "natural" the Medical Examine Completed by	70000	15. Decedent's Education (Specific Elementary/Secondary (0-12) 12th	or Dates: cify only highest grad College (1			ost of work	ing life. D	n (Give kind of 00 NOT use ret		16b. Kind o	f Business	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	3	7. Father's Name (First, Middle, JOSEPH A. M	CQ UEARY				18	PEARL	LATTIM		ame)	
atic aris	2	9a. Informant's Name/Relations PEARL LATTIMOR 0a. Method of Disposition	E/MOTHER			IDGE	ROAD	SE WAS		N,DC 20	019	or Town, State
Baltimore, MI permit. Pages I and 2.9 permit. Pages I and 2.9 Department of Health a Important: If item 27 injury or other traum	L	1 Surial 2 Cremation 4 Donation 5 Other Sc 21. Signature of Funeral Service	pecify:		RMONY C	EMETE	ddress o	f Facility J.		KINS FU	INERA	,MARYLAND L HOME,INC.
Physician /Medical :xaminer	١,	3a. Part Enter the disease, or failur. List only on cause mmediate Cause (Final disease or condition resulting in death)	on each line. a. Cardiac	Arrhyt	n. Do not enter t t hmia							LAND 20785 Approximate Interva Between Onset and Death
red Insit		Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death). Last	b	consequence	of):							
execution and an and an and an and an and an and and		X UNPENDED	d.		II,27,p	er me	,g92	5 3-12-	12 sm			
Division of Vital Records, P.O. Box 68760, the Bospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physici piletely filled in by the funeral director, page 2 should be detached for use as the buildical Certification: To Be Completed by Physician/Med		FFEMALE: Bb. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk	e 1 Live b	ant at time of d	2 Fe	tal death her (Speci	3 [Ectopic pregna	ancy	23d. Dat Mont	e of delive h	ry Day Year
ires that the signed by to the detache		Part II. Other significant conditions Moderate cor										o the cause of death? obably 4 Unknown
Records, The law requir cate has been s page 2 should I		compact atri	oventricu	lar nod	e;obesi	ty			per	is an 24 opsy formed? s 2 No		
Division of Vital Records, P.O. falor Attending Physician: The law requires that the safer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced in by the funeral director. Be Completed by Fartification: To Be Completed by Fartification:	3 2	5. Was case referred to medical examiner? 1	28a. Date (Month		ER/Outpatient	3 DO	oA Ot	at Work?	ng Home 5	Residence e how injury oc		er:
Division of Vi Hospital or Attending Physi 24 hours after death. Funeral Director: After this tely filled in by the funeral director.		2 Accident Inves 3 Suicide 6 Could 4 Homicide	tigation	e of Injury - At h	nome, farm, stree			s 2 No	28f. Location or Town,		imber or R	tural Route Number, City
To the Hospit within 24 hour To the Funers completely fill	2	ne) 2 Medical Exam	nysician: To the bes niner:On the basis of and manner s	of examination a		tion, in my	pinion, d	leath occurred		te and place, a	nd due to t	he cause(s)
•							C.C.M.			January		onth, Day, Year)
0	1		nt Medical Exar	miner 900	W. Baltimoi	re Street	, Baltim	nore, MD 21	1223		1,1	
State Registra		1. Date filed (Month, Day, Year)	19 A 32. Re	egistrar's Signat	sale	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 01340 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year UMBINE MIDALETON 05:52AM JANUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CARROLI IEW NURSING HOME MOUNT 8. Date of Birth __(Month, Day, Year) Jいいこ,14,1922 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 23838198 1 - M 2 5 Months Days SCI Yrs. North Carolina Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at **Funeral Director** MD Carroll Mt. Airy 1 Yes 2XXNo 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a 4101 Old National Pike 21771 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. ō ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: natural" Completed 3€XWidowed 4 □ Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than 'r Elementary/Seconday (0-12) 12th College (1-4 or 5+) the Dietary Manager Plesant View NH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rov Lee Tritt Fannie Barr Morrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) per it. Page 1 and 2 sh Decartment of Health an Important: If item 27 is an; injury or other trau once. 7209 John Pickett Rd. Woodbine, MD 21797 Onna Warfield (Granddaughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/28/2012 4 ☐ Donation 5 ☐ Other (Specify) Middleton Cem Tuckasegee, NC 21. Signature of Funeral Service Licensee Burrier-Queen Funeral Home and Crematory, P.A. 212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ LARDIOPULMONBRY FAILURE one dim Medical resulting in death) Due to (or as a consequence of) Examiner one Atrial Fibrillation ORONARY ARTERY Month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Hypertrusion Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death g Unknown 9 Unknown P.O. 1 ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, ASTHMA 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Discare 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy • Hospital or Attending Physician: The 124 hours after death.
• Funeral Director: After this certificate helefed filled in by the funeral director, page performed 2. No 1 🗌 Yes Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes ☐ Accident Investigation Could not be 2 🗌 No 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type Print) + 308, Columbia, N. VELLANKI, 8850, COLUMBIA 100 PARKWAY: # 308,

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MORRISON Month Physician/ ILLIAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROAD BEAVERBROOK BAUIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth **Funeral** (Month, Day, Year) 217-24-1669 Hours Director 1 XM 2 □ F 82 Yrs GEDRGIA 03-13-1929 28a-f shov 10a. State 10d. Inside City Limits 10c. City, Town or Location with the Maryland notified at Director MD BATIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code or 10g. Citizen of What Country? items 23a or ner must be r Funeral USA BEAVERBROOK 21212 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 1 Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify: BLACK "natural" 3 ₩ Widowed 4 □ Divorced Completed th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) PORT AUTHORITY College (1-4 or 5+) RERVISOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MORRISON WILLIAM INEZ WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 7939 POLK ST. GLENARDEN, MD. 20706 A. MORRISON 27 of Health Department of Health Important: if item 27 any injury or other tr ERIC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
ARBUTUS CEMETERY 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MD 1/27/12 4 Donation 5 Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERITY SCUS 21. Signature of Funeral Service Licenses 4905 NO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trar attending physician and I for use as the burial-tra Due to (or as a consequence of): Division of Vital R-cords, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The law equires that the death Month Day 5 Other (specify) Pregnant at time of death eral Director; After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director, After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 21 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending Natural 2 Accident work?
1 Yes 2 No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balt 170. 2-130

State Registrar 32. Registr

12-00516	5
Cynthia I	Medlen
F Medical	Physici Exam

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nthia Medlery		State of Maryland	/ Departm			Menta	ΪНуς	giene	2	0 1	2 0 1 2 1
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)	Certific	ale UI	Death		12	Re-	g. No.	11	3. Time of Death
edical Exami								Month January 18		r	1705 hrs
		4a, Facility Name (if not institution, give street and number)		4	b. City, Town, or L	ocation of [4c. County of	of Death	
		Stanwood Avenue			Baltimore						
Funeral			e (In yrs. last birt	hday)	If Under 1 Year	If Under 2		8. Date of Birth	(MM/DD/YYYY	Foreign	hplace (State or
Director		229-08-3014 _{1 M 2 F}	55	Yrs.	Months Days	Hours	Min.	Jan.2	3,1956	Cou	^{intry)} VA
	ĺ	Usual Residence of Decedent	La au a		· · · · · · · · · · · · · · · · · · ·						
w any		10a. State 10b. County MD	10c. City, Town	or Locati							10d. Inside City Limits 1 XYes 2 No
yland -f shc	ţo	10e. Street and Number	Das	LCIII				- [40	- Citiman of MA	21.02	
ne Maryland or 28a-f show	Director	16 80 30 5255			10f. Zip Code			10	g. Citizen of Wh	at Coun	try ?
after death with the Maryland *al", or items 23s or 28s-f sho iner must be notified at once.		4228 Stanwood Ave. 11. Marital Status 12. Was Decedent	Ever in II S	I 13 Was	21206 Decedent of Hispa		2 (Spec	ify Ves or No.	USA 14 Page	- Ameri	can Indian, 8lack,
item	unerai	1 Never Married 2 Married Armed Forces?	·		es, specify Cuban, I				White		Sair Malan, Oldon,
fler d	<u> </u>	3 Widowed 4 Divorced If Yes, Give Yeer	No No	1 🔲	Yes 2X No	specify:			Specify:	Bla	ck
ours a	d by	15. Decedent's Education (Specify only highest grade com	npleted) 16a. l		's Usual Occupation			k done	16b. Kind of Bu	siness/Ir	ndustry
72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5	5+)		st of working life, [Veter		
within reference	틹	2 yrs	. Pł	narm	acy Tec						ration
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last) Lexie Sprague						irst, Middle, M Tucke	aiden Surname)		
212 ald be Menta mark	To Be	19a. Informant's Name/Relationship (Type, Print)	198	o. Maiting	Address (Street a					n. State	Zip Code)
MD 21; d 2 should b lth and Men a 27 is mar	-	Bertha Spigner (siste:			Cliftm						
	1	20a. Method of Disposition		of Disposi	tion (Name of ceme				20c. Location -		
Baltimore, permit. Pages l ar Department of Hee Important: If ite njury or other tr		1 Bunial 2 Cremation 3 Removal from Sta 4 Donation 5 Other Specify:			nt Crem	atdr	an. Y	23,20	IZ Ba.	Ito	,Md.
alti mit. partm ports ury o		21. Signature of Kuneral Service Licensee		22. N	ame end Address o	of Facility] !!		
CO SOL		(69)		14	vin B. 12 E. P	rest	ggs on	st. B	alto,M	ne d.	21213
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do no	t enter th	e mode of dying, s	uch as card	liac or re	espiratory arre	st, shock, or hea	rt	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)		Cardio	ovascular Dise	ase					Death
, all		Date to for the december	equence or):		,						
	ě	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	equence of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a conse	equence of):								
uted id ransit	Ä	events resulting in death) Last Due to (or as a conse	34431100 01).								
be executed ician and urial - transi	dical	UNPENDED X AMENDED #4a	nerMF o	,923	1/23/201	2 WS					
760, cate b		IF FEIVALE. 230. II yes, outcom	ne of pregnancy	,723,	1/23/201	2 , W D			23d. Date of	delivery	
lox 68760 eath certificate b attending physi for use as the bu	cian/Me	23b. Was decedent pregnant in the past 12 months?	time of death			Ectopic pr	egnanc	у	Month	D	ay Year
Box 6876(death certificate he attending phy; d for use as the b	Physic	1 Yes 2 No 9 V Unknown 9 Unknown	time of death 5	Oth	er (Specify)						
O. Bo at the de lby the		Part ii. Other significant conditions contributing to death	but not resulting	in the u	nderlying cause giv	en in Part I		23e. Did tob	acco use contri	oute to t	he cause of death?
ords, P.C. w requires that as been signed is should be deta	d b							1 Yes	2 No 3	Prob	ably 4 🗹 Unknown
rds requi	iete							24a. Was ar autops			opsy findings available
eco he law tte has	Completed				-		_	perform	ned? d	eath?	
ician: The certificate rector, page		25. Was case referred to medical		_		f Death (Ch	neck onl				<u> </u>
Vital Rehysician: The this certificate	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie	nt 2 ER/Ou	utpatient	3 DOA	ther ₄ N	lursing l	Home 5 F	Residence 6	Other:	Scene
ling Ph After a	Ë	27. Manner of Death 28a. Date of Inju (Month, Day Yo	ry 28b. 7	Time of In				d. Describe ho	ow injury occurre	d	
ttendi death.	atio	1 V Natural 5 Pending 2 Accident Investigation			1 Ye	s 2 No	0				
Division of Vital Records, P.O. potal or Attending Physician: The law requires that tours after death. reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deac	Certification:	3 Suicide 6 Could not be 28e. Place of Inj	jury - At home, fa	rm, stree	, factory, office bui	Iding, etc.	28	8f. Location (St or Town, Sta		r or Rur	al Route Number, City
ospita hours uneral		4 Homicide							· · · · · · · · · · · · · · · · · · ·		
Division of Vital Records, P.O. Box 68760, vithin 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medicai	one) 2 Medical Examiner: On the basis of exam	y knowledge, dea mination and/or ir	itn occurr ivestigati	ed at the time, date on, in my opinion, d	and place death occur	, and du red at th	ie to the cause ne time, date a	(s) and manner nd place, and di	as state ue to the	d. cause(s)
To with Con	Me	and manner stated. 29b. Signature and title of certifier			29c. License				29d. Date signe		
Ma 1		ame I ?			O.C.M	.E.			January 20	2012	
17 M	ŀ	30. Name and address of person who completed cause of d	eath (Item 23a)								
		Ana Rubio MD. Assistant Medical Exam	niner 900 W	V. Baltir	more Street, B	altimore	, MD 2	21223			
	ate	31. Date filed (Month, Day Year) 32. Registrar	r's Signature	4.1							
Regist		OCME	a grave	ICINAL							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 343 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Middleton Month Ol Physician/ Laverne. 9:20 AM 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner University & Maryland Medical Cluter Baltimore City If Under 24 Hrs Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months 1 🗆 M 2 💢 F Director 260-64-6943 71 8-23-1940 Georgia Usual Residence of Decede show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 28a-f 1 🗌 Yes 2 💢 No Anne Arundel MD Severn 10e Street and Number 10f. Zip Code 10g Citizen of What Country? ms 23a or must be n Funeral 21144 United States 100 Otis Drive Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or iter Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give Completed 3 Widowed 4 Divorced African American Year or Dates er than "natur, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Ith and Mental Hygien 27 is marked other the traumatic event, the Nurse Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Ollie B. Young Robert Hampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any injury or other tr 100 Otis Drive Severn, Maryland 21144 William H. Middleton/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 1-24-2012 Crownsville, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 Funeral Service Ace Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Due to (or as a consequence of): Immediate Cause (Final **Physician** disease or condition Medical resulting in death) [']Examiner COYOTAL (LT urter Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine H Cause (Disease or injury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death been signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetes mellitud (type II), happertension, hypertipidemin Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of congestive heart failure 24a. Was an page 2 s autopsy perform death? 1 Yes 2 No Yes 2 director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ြု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29d. Date signed (Month, Day, Year) P27357 01/18/12

Registrar

State

10

DHMH 17 Rev 06-2011

22 S. Greene St. Baltimore MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Negar Nader

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 10 20°1′2 12:00 A M Irene Muller Annie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Mt. Airv Lorien Nursing & Rehab. Center 8. Date of Birth (Month, Day, Yea Feb. 24, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1921 Hours Maryland 1 □ M 2 🎽 F **Director** 216-10-0269 90 28a-f show 10a. State 10b. County 10d. Inside City Limits at 10c. City, Town or Location Director notified Middleburg 1 XYes 2 No Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 ıral", or items 23a o Examiner must be by Funeral 21757 U.S.A. 6115 Middleburg Rd. oermit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White "natural", Completed 3 XWidowed 4 Divorced Year or Dates Health and Mental Hygiene. em 27 is marked other than "natu ther traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) clothing factory seamstress 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Margaret Elizabeth Smith Ephrim Keeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20872 9136 Damascus Rd. Damascus, MD Audrey McDaniel/ niece other tem 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important; If ite any injury or otl once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Middleburg U.M. Cem. 1/13/2012 Middleburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Signal of Funeral Service Licer 22. Name and Address of Facility Hartzler Funeral Home attorine (Union Bridge, MD 21791 6 E. Broadway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Providen/ Chroni disease or condition resulting in death) Medical Due to (or as a consequence of) 1/10/1 **Examiner** Sequentially list conditions. Examine Due to Lities a consequence of cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Other (specify) Pregnant at time of death been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2 autopsy performed?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 K No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

2 M

the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Crabbury Ct Clarkswille MD 21021 32. Registrar's ignatur

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00038578

29d. Date signed (Month, Day, Year)

29c. License number

State Registrar 29a. Certifier

(Check

only one) 29b. Signature and

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01345 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Musmon Month Year Herbert 1354 PM 19 January 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cauter Hopkin Bayview Care Baltimore N/A Johns 6. Sex 1 **X** M 2 **F** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 06 29 1933 Months Days Hours Min. **Director** 033-24-1897 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director North Potonac 1 🗆 Yes 2 🕅 No MD MONTGOMERY 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral Marattion Terrace 20878 USA 9601 items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. o. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours af. Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", any july or other traumatic event, the Medical Process. If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SHIPPER FOOD INDUSTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ PHILLIP MUSMON FANNIE BERKOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE MUSMON / WIFE 9601 MARATHON TERRACE, #104, N. POTOMAC, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🕅 Removal from State cemetery, crematory or other place) SHARON MEMORIAL PARK | 01/22/2012 4 ☐ Donation 5 ☐ Other (Specify) SHARON, MA 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee INC. MD 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ orrest Cardiac disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner orrythmice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Schemie disease heart and Due to (or as a consequence of) attending physician Physician/Medical atheroselerosis as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 1 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed?/ Yes 2 M No certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred Accident 1 Natural 5 \square Pending injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R085513 horande Marco CRUP 1/19/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkius Bayview Chicle Baltimore MD horou De Marco CRUP 5505 31. Date filed (Month, Day Year) JAN 2 3 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Yea 2012 05:37A M JANUARY SYLVIA MARTIN Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** HOWARD DAYTON GLEN HILL ASSISTED LIVING Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. Country) (Month Day Year) 34 NY Director 105-28-1849 77 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 ☐ Yes 2 🎇 No HOWARD DAYTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14269 TRIADELPHIA MILL ROAD 21036 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 X Divorced WHITE event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) NEW YORK CITY d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) BOARD OF EDUCATION FINANCIAL DIRECTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev LIPSKY FELDMAN LOUIS EDITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE MARTIN / DAUGHTER 5921 TRUMPET SOUND COURT, CLARKSVILLE, MD 21029 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/20/2012 BETH MOSES CEMETERY FARMINGDALE, NY 21. Signature of Funeral-Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS.. INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Security list condition if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed?

Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner?
1 Yes Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title certifier -20-12 30. Name and address of person who completed cause of death Item 23a) (Type, Print) #103 Columbia, MD 21044 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death MARLOW Month Physician/ GENE awaly 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Randalls town Examiner 4c. County of Death Northwest HospitaL Baltimor If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Director 1 XM 2 🗆 F 64 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Y Yes 2 ☐ No Baltimore 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 5404 Wabash Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African-American If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Public Schools Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel W. Marlow Lillian E. Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda A. Marlow/Wife 5404 Wabash Avenue, Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department 1-23-2012 Baltimore, MD Metro Crematory 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 1. Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at pily one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner RENAL Gel Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D65843 January, 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Road, Randalls town, HD 21133 Abdallah Kafrouni 31. Date filed (Month, Day, Year) JAN 2 3 2012 32. Registrar's Signature Registrar

		-	State Amend Item	State of Mar 29d per dv	yland / Depa r.,g923.(artment of 01/23/20 tificate of	Health and 12dhb Death	Mental Hy	giene _{Reg. No.} 20	12	01348			
	Physicia	ın/	Decedent's Name (First, Middle, Last)					2. Date of De Month		Year 012	3. Time of Death			
تغدير	Medie Examir	al	Arnold LeRoy Manches 4a. Facility Name (if not institution, give str			4h City Town	or Location of Deat	January h	4c, County		8:50 P M			
	Exami	e	Gilchrist Hospice			Columi			1	loward				
12	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days		. 8. Date of Birl		9. Birthp	place (State or Foreign try)			
	Director		013–16–8562 ₁ 🗵 Usual Residence of Decedent	M 2 🗆 F	91 Yrs.			August 2	26, 1920	Massa	achusetts			
	land show dat	tor	10a. State 10b. County	10	oc. City, Town or Lo	cation				1	0d. Inside City Limits			
	28a-f	irec	Maryland Howard		Columbia				1 Yes 2 X					
	ith the 23a or st be r	Completed by Funeral Director	10e. Street and Number 5222 Lightning View Ro	oad		10f. Zip Code 2104	5		10g. Citizen of V	zen of What Country?				
	tems ser mus	-une		2. Was Decedent Ever		Was Decedent of	Hispanic Origin? (S	e - Americ						
36	after d	by I	1 Never Married 2 Married	Armed Forces? 1 Yes 2 □ No If Yes, Give		f Yes, specify Cub 1 ☐ Yes 2 🕱 N	oan, Mexican, Puerlo o Specify:	o Hican, etc.)	k, White,					
9	atural	etec	3 Widowed 4 Divorced 15. Decedent's Educ	Year or Dates.		dent's Usual Occu				Specify: White 16b. Kind of Business/Industry				
215	n 72 h e. ian "n Medi	dmc	(Specify only highest grade Elementary/Secondary (0-12)		I (Give		during most of wo	rking			leyerhoff			
21	d withi	Be C		4+	Music	cian	1		Entertai					
and	oe filec	To B	 Father's Name (First, Middle, Last) Everett Raymond Manc 	nester			1	me (First, Middle, Brighton	Maiden Surnam	e)				
ary	nould Me s mar umati		19a. Informant's Name/Relationship (Type	, Print)	19b. Mailii	ng Address (Street	t and Number or Ru		r, City or Town, S	State, Zip (Code)			
Σ	nd 2 s ealth a m 27 i		Virginia Manchester	(Wife)		Lightning '	View Road	Columbia	, MD 21045	5	<u></u>			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ R			natory or other pla	ace) 1_1(Date		on - City or Town, State Surnie, Maryland				
Ħ	nit. Pa artmei ortani injury			Atlantic Crematory 1–19–2012 G1 Signatura of Funding Service Ucensee 22. Name and Address of Facility Witzke Funeral										
B	Depar Impor any in		>7/15 K Herd	_ mo	U 31 / I		Knolls Road	Columb	oia, Maryl	and 2	i045			
	Physician/ Medical Examiner	dical Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	ROINCI	NEARC				Approximate Interval Between Onset and Death BAUS			
09	ate be ohysici the bu		d.							_	_			
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of particles of the control of t	Fetal death 3	Ectopic pregnar Other (specify)	ncy			te of deliventh	ery Day Year			
P.O.	that the ned by e deta	oy P	Part II. Other significant conditions cont	ributing to death but r	not resulting in the u	inderlying cause g	iven in Part I.	23e. Did to	obacco use cont	ribute to th	ne cause of death?			
ds,	requires been sig should b	ted	PNEUMONIA					1 🗆	Yes 2 🔀 No	3 🗌 Pro	bably 4 🗆 Unknown			
Records,	sician: The law re s certificate has be lirector, page 2 sh	Comple						24a. Was autoj perfo 1 🏻 Yes	rmed?	Were auto prior to co death? 1 🔲 Yes	psy findings available mpletion of cause of			
/ital	sician certifi irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	spital:	a □ rp/o ++i	Ot	Place of Death (Che			- 10 - 15	HOSPICE			
of \	g Phy er this neral d	te: To	27. Manner of Death	28a. Date of injury (Month, Day, Ye	2 ER/Outpatier 28b. Time of injury		ırv at	Home 5 Resident	now injury occurr		HOTFICE			
lon	tendin eath. or; Aft the fur	ifica	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, 10	sar) Injury	M 1 [Yes 2 No							
Division of Vital	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director, After this certificate he completely filled in by the funeral director, page	al Certificate:	4 Homicide determined	28e. Place of Injury building, etc. (S		eet, factory, office		28f. Location (S City or Tow	Street and Numb vn, State)	er or Rurai	Route Number,			
	Hosp 24 hou Funer stely fil	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	r: On the basis of exam	nination and/or inves	tigation, in my opin	ion, death occurred	at the time, date a	and place, and du	e to the ca	use(s) and manner stated			
	To the within To the Somple		only one) 3 Certifying Nurse 29b. Signature and title of certifier	racutioner: To the be	>-	29c. Licens	se number		29d. Date signe	d (Month,	Day, Year) 2012			
			1	2/	10	Do	64395	5	TANKA	Ry	17, 20H			
_	atl		30. Name and address of person who con	MAN, MO		Print) LEVAR	04395 - LANE	com	MbiA, 1	ns:	21044			
	Sta Registr	e l	31. Date filed (Month, Day, Year) JAN 2 3 2012	32. Registrar's										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marcus 2-011 4:44 P M Nome Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1031 REGINA DRIVE BALTIMORE BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □XM 2 □ F Months Country) 08/15/1936 **Director** 071-28-2430 75 NY Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 X No BALTIMORE BALTIMORE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1031 REGINA DRIVE 21227 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 XYes 2 □ No 2 Black, White, etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 XNo Specify. If Yes, Give Completed 3 Divorced Specify: WHITE Year or Dates th and Mental Hygiene.

27 is marked other than "natur traumatic event, the Medical | 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) RAMP SERVICE MAN UNITED AIRLINES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I ည DAVID MARCUS RUTH SALSMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 ELAINE MARCUS/WIFE 1031 REGINA DRIVE, BALTIMORE, MD or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LEBANON CEMETERY : 01/20/2012 ADELPHI, MD 21. Signature of Funeral Service Ligers 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, Part 1. Enter the disease, or complex tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on cause on each line. 23a. Part 1. Enter the disease. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immufation cause. Enter Underlying Examine Due to (dr as a consequence of) Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be 68760 IE EEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Pregnant at time of death Month Day Year 4 Pregnant 9 Unknown 1 Yes 2 No P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မှ ER/Outpatient 3 DQA 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident To the Hospital or Attendining the hours after death.

To the Funeral Director: All completed filled in by the fu 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and the of certif signed (Month, Day, Year) 1 18

Registrar

DHMH 17 Rev 7/2009

M

State

30. Name and address of person who completed scuse of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 3, 25 Am 2. Date of Death Physician/ CARSON F. MUNN, JR. 2012 Tanuar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore-Washington Medical Center Glen Burnie Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. . Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 215-28-6369 (Month, Day, Year)
July 1, 1933 Director 1 **X** M 2 \square F 78 South Carolina 28a-f show with the Maryland notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code "natural", or items 23a o edical Examiner must be 10g. Citizen of What Country? Funeral 3738 Tenth Street 21225 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 X Yes 2 No
If Yes, Give þ 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 X No Specify Completed 3 Nidowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2121 Elementary/Secondary (0-12) Page 1 and 2 should be filed within 'ment of Health and Mental Hygiene. College (1-4 or 5+) and Mental Hygiene. Boilermaker Union LOcal 193 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carson F. Munn, Sr. Alma Polson Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Lisica (Daughter) 3701 Saint Victor Street, Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Glen Haven Memorial Park 1/21/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Juneral 5 re Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 Fast Patapsco Avenue, Baltimore, Maryland 21225-1856 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ a disease or condition Medical resulting in death) Due to (or as a confequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter I Inderlying Due to (or as a consequence of) attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No Hospita Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending Natural injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 18/12 Va

DHMH 17 Rev 06-2011

State Registrar

0

egistrar's Signatur

State of Maryland / Department of Health and Mental Hygiene 2 0 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav 3 45 AM Physician/ JOSE WEZET NAMBO AUGUSTIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rosedal e FRANKLIN Soua Hospital 50 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 577-12-1220 1 **X**M 2 □ F **Director** 6 8 Yrs. LAmbarene, GADOR 11-10-1943 Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Funeral Director 1 X Yes 2 ☐ No MD BAUIMORE 10e. Street and Number 10g. Citizen of What Country? GABON 21206 UTRECH 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black White, etc. 3 ō 1 Never Married 2 Married Completed by 2 No Yes 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: BLACK "natural" 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT use paired)
DISabled Fatients Courdinativ event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. HEALTHCARE Elementary/Secondary (0-12) College (1-4 or 5+) 12 Be Maryland 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o HMBROISE NAMBO BERTHE OMDINdi other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SERGE WEZET APT 2D. BATTO, MD. Important: If item 27 any injury or other tra FERNSELL Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State FORT GENTIL, GABON

ENTIL

22. Name and Address of Facility VAUGHN GREENE FUNDARISCUS PA 1 Burial 2 Cremation 3 KRemoval from State GENTIL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service 4905 ROAD. BALTO, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician) Pheymoni ASPICATION disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** scierosis Am of reshic Due to (or as a consequence of): LaTeral sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be the funeral director Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hound To the Funer completely file 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 119/12 3048 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V 9000 Franklin Square DR Balto Md 21237 Kanbour Muhannac 31. Date filed (Month, Day, Year) 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01352 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1450 LLIZABETH NITSCH 2012 JAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OF MARYLAND MEDICAL CENTER BALTIMORE UNIVERSITY If Under 1 Year If Under 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 217-38-6368 1 □ M 2 🔀 F **Director** 9/15/1940 71 MD Usual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location Funeral Director 1 Yes 2 X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6127 Northdale Rd. 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc 1 Never Married 2 Married Completed by Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Insurance Verification Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Cook Mary Bannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Nitsch/husband 6127 Northdale Rd., Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burlal 2 Cremation 3 Removal from State 1/23/2012 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catons Ville, Inc. 1630 Edmondson Ave. Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ENCEPHALOPATHY ANOXIC Medical resulting in death) Due to (or as a consequence of) **Examiner** WEEK MYOCARDIAL INFARCTION Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last YEARS Hospital or Attending Physician: The law requires that the death certificate be executed <u>Atherosclerotic</u> P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
☐ Yes 2 ☐ N Yes 2 No ours after death.

eral Director: After this certifica filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) P27328 JAN 19 2012 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

BALTIMORE MO 21230

4th F

ST

PRATT

31. Date filed (Month, Day,

12-0	0594	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

orris Powell, Jr.	1- For State	Department of Certificate of	Health and Mental H Death	ygiene Reg.	201	2 0135	
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)			Date of Death Month	oav Year	3. Time of Death	
ledical Examine			Death and Death	January 21,	2012 4c. County of Death	1221 hrs	
	 4a. Facility Name (if not institution, give street and number) 13205 Old Marlboro Pike 	1	b. City, Town, or Location of Death Upper Marlboro		Prince George'	s	
Funeral		e (In yrs. last birthday)	If Under 1 Year If Under 24Hr	s. 8. Date of Birth ((MM/DD/YYYY) 9. Birth	place (State or	
Director	405-21-7056 1XM 2 F 4	1 Yrs	Months Days Hours Mir	06/29	/1970 Foreign	ntry) KY	
	Usual Residence of Decedent	-					
* any	10a. State 10b. County	10c. City, Town or Locati	on			10d. Inside City Limits 1 Yes 2 No	
Maryland 28a-f show a at once. Pector	MD Charles	Waldorf	10f. Zip Code	1400	. Citizen of What Coun		
he Maryland n or 28a-f sh iffied at once Director	10e. Street and Number 10f. Zip Code 20603				U.S.A.		
sath with the Maryland items 23a or 28a-f sho ast be notified at once,	11. Marital Status 12. Was Decedent	Ever in U.S. 13. Wa	s Decedent of Hispanic Origin? (S		14. Race - Americ	an Indian, Black,	
leath with ritems 23 nust be no	1 Never Married 2 Married Armed Forces? 1 Yes 2	lf Y	es, specify Cuban, Mexican, Puerto		White, etc.	,	
ral", or	3 Widowed 4 Divorced If Yes, Give Year Q C	9-91 1	Yes 2 No specify:		Specify.	ack	
hours and matura		during m	t's Usual Occupation (Give kind of ost of working life. DO NOT use re		6b. Kind of Business/In	dustry	
hin 72 hin 72 than "than "	Elementary/Secondary (0-12) College (1-4 or 5		ity Guard],	Shopping	Mall	
5-0036 ed within 72 hour lygiene. other than "nature Medical Exar	17. Father's Name (First, Middle, Last)	150041		e (First, Middle, Ma			
215 be file mtal H rked o			Mary M				
MD 21215-0036 at 2 should be filed within 7 lth and Mental Hygiene. at 7 is marked other than numatic event, the Medica	19a. Informant's Name/Relationship (Type, Print)		Address (Street and Number or				
	Mary Powell 20a. Method of Disposition		Woolfolk, Box		20c. Location - City or		
	1 Burial 2 Cremation 3 Removal from Sta	crematory or other	· · · · · · · · · · · · · · · · · · ·	26-12	Providenc	e. KY	
Baltimo permit. Page Department or Important: injury or oth	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Cumberla	ame and Address of Facility JO				
Depa Depa	Tall	30	1 N. Broadway	, Provi	dence, KY	42450	
Physician	23a. Part / Enfer the disease, or complications that caused failure. List only one cause on each line.	the death. Do not enter t	ne mode of dying, such as cardiac	or respiratory erres	t, shock, or heart	Approximate Interval Between Onset and	
!Medical :xaminer	Immediate Cause (Final disease a. Multiple Blunt F	orce Injuries				Death	
-Aanniner	or condition resulting in death) Due to (or as a conse	equence of); .					
ā	Sequentially list conditions, if any, leading to immediate Due to (or as a const	equence of):					
red Insit	cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a const	equance of):					
ansit de d		equence or).					
be executed sician and urial - transit	UNPENDED AMENDED						
760, cate bo physic the bur	IF FEMALE: 23c. If yes, outcome and the second seco		a □=+ :		23d. Date of delivery	av Year	
Box 68760, e death certificate by the attending physical for use as the burdeling physical for use as the burdelician Meanifican Mea	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1						
BOX e death the atte	1 Yes 2 No 9 Unknown 9 Unknown						
P.O. B es that the d igned by the detached the detached the detached the detached the Day		h but not resulting in the	underlying cause given in Part I.		acco use contribute to t		
cords, P.O. law requires that has been signed be standard by				24a. Was an		opsy findings available	
Records, The law requires freate has been sig				autopsy	prior to c	ompletion of cause of	
tal Rec				1 ✓ Yes 2	No 1 ✓ Ye	s 2 No	
ital ician: s certif rector,	25. Was case referred to medical examiner? [Hospital: 4]	ent 2 ER/Outpatien	26.Place of Death (Check 3 DOA Other		esidence 6 🗸 Other	Scene	
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the statistication: To Be Completed.	1 Yes 2 No 27 Manner of Death 28a Date of Inju	ury 28b. Time of		28d. Describe ho	ow injury occurred		
sion (death. ctor: Af	1 Natural 5 Pending FOUND: Day.		1 Yes 2 ✔ No	Subject was a	assaulted		
Division pital or Attent ours after death teral Director: filled in by the	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Ir		et, factory, office building, etc.	or Town Sta	reet and Number or Ru		
Division o spital or Attending sours after death. neral Director: After filled in by the fune	4 V Homicide determined (Specify) In	car in parking lot		Found: 13205 (Old Marlboro Pike, U		
		y knowledge, death occu mination and/or investiga	rred at the time, date and place, ar tion, in my opinion, death occurred	d due to the cause at the time, date ar	(s) and manner as state nd place, and due to the	ed. e cause(s)	
To the Ho within 24 To the Fu completed	and manner stated 29b. Signature and title of certifier		29c, License number		29d. Date signed (Mor		
311	1////		O.C.M.E.	İ	January 22, 2012		
OGNIE	30. Name and address of person who completed cause of death (Item 23a)						
	Mary G. Ripple MD. Deputy Chief Medi		W. Baltimore Street, Balt	imore, MD 212	223		
Stat		ar's Signature					
Registra	JAN 2 3 2012 Denega A	· jugarous					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jan 3:12 AM 2012 stephen reters Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard County Columbia Howard General Hospita Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 212-20-9816 Director 1 🏝 M 2 🗆 F Maryland 3, 1925 86 Aug. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 🔀 No Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 USA 1436 Forest Park Avenue ral", or items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1944–46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 → Widowed 4 □ Divorced "natural", Specify: White Completed Medical 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ed other than " Elementary/Secondary (0-12) College (1-4 or 5+) C&P Telephone Company 4 Engineer of Health and Mental Hygien item 27 is marked other to other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Catherine V. Meushaw George A. Peters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 940 Grovehill Road; Baltimore, MD 21227 19a. Informant's Name/Relationship (Type, Print) Stephen Peters, Jr. Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Mem. Park 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If it any injury or o once. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/24/2012 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Ligens 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** neumonia Sequentially list conditions, Tany Inacing to immedicause. Enter Underlying tract in fection. Exami cate has been signed by the attending physician and page 2 should be detached for use as the burial-trans Cause (Disease or injury Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant g Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Pulmonary 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 pronar certificate 1 Yes 2 No filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death, Funeral Director: A Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F

complete the only one) 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) D42892 2012

State

DHMH 17 Rev 06-2011

Registrar

Lane

5755 cedar

Columbia MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francis Chuidian

31. Date filed (Month, Day, Year)

12-00435							
Barbara Poole							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012	01	3	5	1
------	----	---	---	---

		For State		Cer	tificate d	of Death			eg. No.	2 0100
Physician Medical Examine	7 1	. Decedent's Name (First, Middle Barbara	e,Last)	Pool	le			2. Date of Deal Month January 1		3. Time of Death 1630 hrs
	4	a. Facility Name (if not institution 727 Druid Park Lake D		umber)		4b. City, Town, or Baltimore	Location of De	ath	4c. County of Dea	
Funeral Director		214-38-9630	6. Sex	7. Age (In yrs. la	ast birthday) Y	If Under 1 Year Months Day		Hrs. B. Date of Bin	Fore	irthplace (State or ign ountry) DE
aryland 8a-f show any at once,	1	Isual Residence of Decedent Oa. State 10b. County MD	NA		Town or Local					10d. Inside City Limits 1 X Yes 2 No
or items 23s or 28s-f sho		0e. Street and Number 727 Druid Pa					217		og. Citizen of What Co USA	
		1. Marital Status Never Married 2 Ma Widowed 4 Divo		2 🔀 No	lf	/as Decedent of His Yes, specify Cubar	n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	- 14. Race - Ame White, etc.	rican Indian, Black, African Erican
1215-0036 doe filed within 72 hours after fental Hygiene. sarked other than "natural", event, the Medical Examiner	I bieren n	15. Decedent's Education (Spec Elementary/Secondary (0-12) GED			during	ent's Usual Occupa most of working life Nurse			Rosewood Hospi	d State
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than sumatic event, the Medica	8	7. Father's Name (First, Middle,	Last) unk				18.Mother's Na	me (First, Middle, M	Maiden Surname) U	nk.
and 2 should fealth and Mereten 27 is marter every fraumatic every 15 marter e	L	9a. Informant's Name/Relationsh Vacshon Brov Oa. Method of Disposition			212		wood A		nber, City or Town, State Baltimore I 20c. Location - City of	e, Zip Code) 1
Baltimore, MI permit Pages I and 2.8 Department of Health a Important: If item 27 injury or other traum	1	X Burial 2 Cremation Donation 5 Other Sp Signature of Funeral Service	ecify:	om State	rematory or c rinit			1-24-12	Baltim	ore, MD
Physician	1	Simela	Sum	zeton. adsed the death.	_ 6	38 N. G	ilmor	Street	Suneral H Baltimor est, shock, or heart	e, MD 21217
/Medical Examiner		23a. Part I. Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Death								
iner		Sequentially list conditions, b								
0, e be executed sician and burial - transit		Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of	·):					
Box 6876 The death certificate the attending physical are as the by section of the attending physician/M		UNPENDED FEMALE: b Was decedent pregnant in the past 12 months? Yes 2 No 9 Unkart II. Other significant conditions	1 Live b 4 Pregr nown 9 Unknown	ant at time of dea	2 Fath 5 0	etal death 3)ther (Specify) underlying cause			23d. Date of delive Month	Day Year
Records, P.O. The law requires that it ficate has been signed by page 2 should be detach	nandin							24a. Was a autop	sy prior to med? death?	utopsy findings available completion of cause of
Vital Rec ysician: The his certificate director, page	2	5. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier		of Death (Chec	ck only one)	2 ✓ No 1 1 No	r: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death. To Director: After this certificate has been sited in by the funeral director, page 2 should be artification: To Be Completed		7. Manner of Death 1		of Injury , Day,Year)	28b. Time of		ry at Work? Yes 2 No		now injury occurred	
Division of V E Houpital or Attending Ph 24 hours after death. e Funeral Director: After to etely filled in by the funeral 23 Certification: T		Suicide 6 Could Homicide deten	not be mined (Specify)			eet, factory, office t		or Town, S	tate)	ural Route Number, City
To the Hos within 24 h To the Fun completely	200	official of the	niner:On the basis and manner s	of examination ar			n, death occurre		e(s) and manner as sta and place, and due to t 29d. Date signed (M	he cause(s)
		D. Name and address of person	11	se of death from	239	O.C.			January 19, 201	
		Zabiullah Ali, M.D.	Assistant Medic	a! Examiner	900 W.	Baltimore Stre	et, Baltimor	e, MD 21223		
State Registra	e ³	1. Date filed (Mogra Ry 2°3		egistrar's Signatu	ha	Kel				9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 ROBERT L. POTTER JANUARY 7:44 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 733 NARROWLEAF DRIVE UPPER MARLBORO 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □**X**M 2 □ F Months Hours (Month, Day, Yea ALABAMA Director 217-32-3358 78 1933 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1√ Yes 2 □ No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 733 NARROWLEAF DRIVE 20774 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No ARMY Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK 3 😾 Widowed 4 🗆 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th CHEF GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GUY HANLEY POTTER FORD TEXANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FORD/SISTER 11106 WEBBWOOD COURT UPPER MARLBORO, MARYLAND 20774 DONNA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD VETERANS CEMETERY 1/26/2012 CHELTENHAM, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Edier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ► Physician/ anant disease or condition OKNOWA Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year g Unknown the detached g Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🔀 No s after death.

Director: After this certificate! 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 A Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🔯 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C To the Hospital Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D2500 01-20-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LARGO MP 20774 JAY LIPPMAN MA 9200 BASIL CT 31. Date filed (Month, Day, Year) JAN 2 3 2012 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2043 PM 2013 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan. 5, 1927 **Funeral** Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 - F 85 Mary Tand Director Yrs. 212-20-8697 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified 1 Yes 2 X No Maryland Calvert Chesapeake Beach 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 3921 13th Street 20732 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Meat Cutter Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Joseph Ritter Anna Marie Adrian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry Ritter Son 3921 13th Street; Chesapeake Beach; MD 20732 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 1-22-2012 Glen Burnie, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (d) as a consequence of): Examiner quentially list nonditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No cate 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2**X** No Other: 1 🗌 Yes မှ 1 ♣ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pendina work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20061783 20/2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick MI

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Month Eric Edward Spence 0923 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITal Baltimore Agnes 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Min. Director 16-2012 Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 1629 Ingleside Apt. F 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 XNever Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Chi</u>ld <u>Child</u> traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o ပ္ Erica Shuler Edward Spence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1629 Ingleside Apt.F Balto., MD 21207 Erica Shuler/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ö 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once, 1-25-2012 Hanover, MD Ardent Crem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Phillip A Weatherford FS PA 2431 E.Oliver St. Balto. MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ umonar disease or condition resulting in death) hours Medical Due to (or as a consequence of) Examiner nours organization is the conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that the death certificate be executed burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ distress syndrome 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hospital or Attending Physician: The law requires Certificate: To Be Completed congenital anemia 24b. Were autopsy findings available prior to completion of cause of death? hypotension. 24a. Was an mëtabolic acidosis perform 1 Yes 2 No Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XN0 Other: 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral L 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, weath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 40780 anuary 16,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD trenuc 900 Molone aton 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\text{Day}}{15} \, \underline{\overset{\text{Teal}}{2012}}$ Physician/ **EMMA** SHIELDS-WATTS JANUARY 3:39 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 111804 CHANTILLY LANE PRINCE GEORGE'S MITCHELLVILLE Social Security Number 8. Date of Birth (Month, Day, Ye NOV • 19 If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days Hours Director 252-36-6829 101 GEORGIA 1910 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland must be notified at Director 28a-f 1X Yes 2 □ No MD PRINCE GEORGE'S MITCHELLVILLE ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 111804 CHANTILLY LANE 20721 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 9 1 Never Married 2 Married 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK If Yes, Give "natural", Completed 3 🕱 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6th DOMESTIC other PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked မ GARFIELD SHIELDS **EMMA** LAWSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Health a GLORIA WATTS-DAVIS/DGT 111804 CHANTILLY LANE MITCHELLVILLE, MARYLAND 20721 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite Date 20c. Location - City or Town, State 0 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 1/25/2012 ATLANTA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. RUSA 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Er er the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, wheart filter. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner FAILURE TO THRIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events y physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 **X** No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 2 XNo Hospital Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred I or Attending F after death. (Month, Day, Year) 1 XNatural 5 Pending after death. Accident
Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined Hospital Funeral Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only on Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

68760 P.O. Division of Vital Records, completed filled in by

State

Registrar

29b. Signat

30. Name and address

PETER

7500 GREENWAY CENTER DRIVE #430 GREENBELT, MARYLAND 20770 SCHISSLER M.D. 31. Date filed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D22780

JANUARY 17, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Charles E. Smith, Jr. 2012 8:22 Medical Jan. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2008 Amberleaf Place #35 Charles Waldorf Social Security Number 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Days Min. Hours 1 🔀 M 2 🗆 F Director 35 Yrs. 358-72-8510 7-76 Indiana 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f XYes 2 No MD. Charles Waldorf 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2008 Amberleaf Place #35 20602 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Examiner Black, White, etc. 0 Completed by 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: "natural" Specify: Black 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry uld be filed with...d Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other the Auto Parts Specialist NAPA event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles E. Smith, Sr. **JoAnne Reynolds** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 2008 Amberleaf Place, Regina Smith/Wife #35 Waldorf, Md 20602 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Heritage Memorial 1/27/12 Signature of Funeral Service Licensee

22. Name and Address of Facility

Hackett's Funeral Chapel,

814 Upshur Street NW D

art 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nediate Cause (Final Waldorf._Md Inc. c. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 300c disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury that initiated events physician and s the bunal-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Day 2 No ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an Jas prior to completion of cause of death? autopsy performed? page certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the eleted filled in by the funera 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 1 within 2

State Registrar 29b. Signature and title of certifier

Krishan M.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mathur,

32. Registr 's Sign

29c. License number D28352

M.D. 3500 Old Washington Rd S102 Waldorf

20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 20 12 1:00 P M Gertrude E. Spurrier Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick St. Catherine's Nursing Center Emmitsburg If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Year) 913 Mar. Pay, 1 🗆 M 2 🕱 F Days Maryland **Director** 212-03-1057 98 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 No Frederick Emmitsburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21727 U.S.A. 333 Seton Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) clothing factory 8 seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Barbara Kohles Edward Steinberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Union Bridge, MD 21791 13134 New Windsor Rd. Audrey L. Fox/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 1/19/2012 nr. New Windsor, MD 4 ☐ Donation 5 ☐ Other (Specify) Greenwood Cemetery 22. Name and Address of Facility Hartzler Funeral Home 21. Sign of Fyeeral Service Licens atharin Box 249 New Windsor, MD 21776 Approximate Interval Between Orset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Tue to (or as a consequence of) **Examiner** eaus Sequentially list conditions. any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of s been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown 9 Unknow Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by as 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital ၀ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 27. Manner of De 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural Accident injury 5 Pending Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

DHMH 17 Rev 7/2009

only one) 29b. Signature and

lan 31. Date filed (Month,

2

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registar's Sig

Sctor

Certifying Nurse Practioners, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0018

MT

21727

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 2

			For	State of N	/larylan	id / Depa	artment of	f Health	and N	lental Hyg	iene 2	112	01362
			State Registrar			Cer	tificate of	f Death		R	leg. No.	J 1 C	01001
	Physicia	ın/	Decedent's Name (First, Middle	, Last)						2. Date of Deat Month	th Day	Year	3. Time of Death
. Alice	Medic	al	HOWARD	W. STAN		IV				January		012	6:50 p ^M
	Examin	er	4a. Facility Name (if not institution,				4b. City, Town		of Death			y of Death	E CO
	Funeral		STELLA MARIS 5. Social Security Number			ast birthday)	TIMON If Under 1 Yes		24 Hrs.	8. Date of Birth		TIMOR	blace (State or Foreign
	Director		216-48-9256	1 🗓 M 2 □ F		63 Yrs.	Months Day	/s Hours	Min.	(Month, Day,	Year)	Coun	try)
	_ MC		Usual Residence of Decedent							APR. 2	1948		YLAND
	yland -f shc ed at	ctor	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	e Mar r 28a notifi	Director	MARYLAND BALT	IMORE CO			T404 71- 0-4	ESSEX					1 Yes 2X No
	ith th	rall		TEDM OF			10f. Zip Code				10g. Citizen of		ntry?
	ath w	Funeral	251 SOUTH EAS'	12. Was Decedent	t Ever in U.S	S 13 V	Vas Decedent o	221 f Hispanic Ori	igin? (Spe	cify Yes or No-	U.S.,	A •	an Indian
ထ	er de or ite mine	by F	1 Never Married 2 X Marr	Armed Forces	?	It	Yes, specify Cu	uban, Mexicar	n, Puerto	Rican, etc.)		ack, White,	
<u>8</u>	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	pe	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	/72	1	Yes 2 X	No Specify.	:		Specif	BLAC:	Κ
2-(2 hou "natu edica	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)			ent's Usual Occ		t of worki	ng	16b. Kind of I	Business/In	dustry
7	thin 7 the.	mo.	Elementary/Secondary (0-12)	College (1-4 or	r 5+)	life. Do	O NOT use retire	ed)			E V C TL E.	דמ זאם	ATTING CO
N O	ed wi Hygie other	Be (12th grade 17. Father's Name (First, Middle, L	2yrs		PLAT	ER ANAOI		ar's Name	e (First, Middle, N			ATTING CO
au	be filed ental Hy ked oth ic event	은	HOWARD W. STA	,						E TURNE		10)	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationsh			19b. Mailin	a Address (Stre			l Route Number,		State, Zip (Code)
	and 2 sh Health a tem 27 is		Patricia Stanle	ev/Wife			•			Ct., Es	-		
e,	ge 1 and tof He		20a. Method of Disposition	•		Place of Dispo	sition (Name of natory or other p				20c. Location		
Ĕ	Page 1 ment of ant: If it ury or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		i G	-			01-26	5-2012	MIDDLE	RIVE	R, MD.
Baltimore,	permit. Page Department Important: I any injury o once.		21. Signature reral Sergice L	icensee		22	Name and Add	cress of Facili	WN CO	OMM FUNE	RAL HO	ME-HA	RFORD, P.A.
П			23a. Part 1. Enter the disease, or shock, or heart failure. List o									21001	Approximate Interval Between
SU VA	Physician/	3 1	Immediate Cause (Final disease or condition	_ a CEREBI	ROVASO	ULAR A	CCIDENT	£					Onset and Death
	Medical Examiner		resulting in death)	Due to (or as	s a consequ	uence of):							
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequ	uence of):							
	ted Insit	Examiner	Cause (Disease or injury										
	execu an and ial-tra	Exa	that initiated events resulting in death) Last	C. Due to (or as	s a consequ	uence of):							
09	death certificate be executed ne attending physician and ed for use as the burial-transit	dical	,	d									
6876	tifical ing ph e as tl	Med	IF FEMALE:	T	=. 0								
	eath certifical attending ph d for use as tl	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	n 2 🗌 Feta	aldeath 3 🗌	Ectopic pregna					ate of deliver	ery Day Year
Вох	e dea the a	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ∐ Pregnant 9 ☐ Unknowr		death 5 ∟	Other (specify)				"		2,
0.	The law requires that the death ate has been signed by the atte page 2 should be detached for	y Ph	Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	nderlying cause	given in Part	l.	23e. Did tol	oacco use con	tribute to th	ne cause of death?
	uires t n sign uld be	d by								1 □ Y	es 2 🗆 No	3 🗌 Pro	bably 4 💢 Unknown
ord	v requ	olete								24a. Was a		Were auto	psy findings available
ec €	'sician: The law r s certificate has b lirector, page 2 s	Completed	_							autops perfori 1 Yes	med?	death?	mpletion of cause of
a	ian: T rtifica ctor, p	Be C	25. Was case referred to medical examiner?				26.	Place of Dea	ith (Check		2 23 NO	1 100	
Ĭ	hysic his ce al dire	10	1 Yes 2 No			ER/Outpatien	t 3 🗆 DOA	other: 4 🗆 N	ursing Ho	me 5 Reside	ence 6X Otl	ner (Specify	HOSPICE
101	ing P	ate:	27. Manner of Death1 Natural 5 Pendin	28a. Date of in (Month, D	jury Jay, Year)	28b. Time of injury		ork?	- 1	28d. Describe ho	w injury occur	red	
Ö	ttend death tor: /	Certificate:	2 Accident Investig		aium. At bo	ma form atra		Yes 2		006 1	and and Alama	han an Orma	Deute Alumbay
Division of Vital Records,	pital or Attending Physician: ours after death. eral Director: After this certific filled in by the funeral director,	Cer	4 Homicide determine		etc. (Specify		et, factory, offic	-		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	Hos Hos Fun tely	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of	examination	n and/or invest	igation, in my op	inion, death o	ccurred at	the time, date an	d place, and d	ue to the ca	use(s) and manner stated.
	To the Hos within 24 ho To the Fun completely	Ž	only one) 3 X Certifying 29b. Signature and title of certifier	Nurse Practitioner: To 1	tne best of n	ny knowledge,		at the time, da nse number	ite and pla		e cause(s) and 29d. Date sign		
	Make		14 Sul	ACMAIP			RI	4970	12		1/19	2017	
	104.24		30. Name and address of person v	who completed cause of	death (Item	1 23a) (Type, P	rint)		•		-11-1	-	
	\		JACKIE JONES,				LEY RD.	. TIMO	ONTUM	1, MD 21	093		
	Stat Registra		31. Date filed (Month, Day, Year)	2 Security	trar's Signat	park							
			A1111 14 A	/ - / · · · · · · · · · · · · · · · · ·		_							

DHMH 17 Rev 06-2011

6:50 p.m.

JANUARY 18, 2012

HOWARD STANLEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 01363 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 14 2012 **JEAN** SWANN 8:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CAPITOL HEIGHTS PRINCE GEORGE'S 801 IONA TERRACE 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday Min. Hours VIRGINIA Director 578-54-1293 1 M 2 XF 71 JAN 10 1941 Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗌 No MD PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 801 IONA TERRACE 20743 USA ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Specify: BLACK 1 ☐ Yes 2 X No Specify: "natural", 3 XWidowed 4 □ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th TEACHER GOVERNMENT marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental ည EUGENE HERBERT HARRIS DOROTHY **JEAN** CLARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health item 27 JOHN CLAYTON/SON 16300 EDDINGER ROAD BOWIE, MARYLAND 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 🌠 Burial 2 🗆 Cremation 3 🗔 Removal from State Ponation 5 Other (Specify) 1/20/2012 LANDOVER, MARYLAND HARMONY CEMETERY Signature of Funeral Service J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 2 nset and Death Immediate Cause (Final 11 bladde Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical phys the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 prioriths?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Month Day Year 1 Yes 2 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 TYes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 C 4 Nursing Home မ 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 (Control Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending Powithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending injury 1 🗌 Yes 2 \square No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifier

earine 31. Date filed (Month, Day, Year)

JAN 2 3

canine Wenny, MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Werner, MP

2012

Maryland 21215-0036

Baltimore,

68760

Box

P.0.

Records,

Vital

of

Division

2003

32. Registrar's Signature

DS2830

Medical Parking

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 ่ ไว้ Richard Francis Umstead January 9:01 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll New Windsor 2831 Carlisle Drive If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In vrs. last birthday Days Director 211-22-8281 1 XM 2 | F Yrs 81 Mar. 26, 1930 Pennsylvania or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryland Director 1X Yes 2 No New Windsor Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hyglene. The fact of Health and Mental Hyglene. The marked other than "natural", or items 23a lury or other traumatic event, the Medical Examiner must bury or other traumatic event, the Medical Examiner must bury or other traumatic event, the Medical Examiner must but a most bury or other traumatic event, the Medical Examiner must but a most but a most but and a most but 2831 Carlisle Dr. 21776 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) deli manager grocery store 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Helen Anna Kohl William E. Umstead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
921 Grayson Square Bel Air, MD 21014 921 Grayson Square Susan H. Chanski/daughter Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 3 Cremation 3 Removal from State Sykesville, MD 4 Donation 5 Other (Specify) All County Cremation 1/17/2012 Signatur of Funeral Service Licens 22. Name and Address of Facility Hartzler Funeral Home athan 310 Church St. New Windsor, MD 21776 Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in radiate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) Exami or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? this certificate has page 2 performed 2 No Yes 2 No 1 Yes s after death.

Director: After this certific d in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

29b. Signature and title of certifi

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month $2\overset{\text{Year}}{0}\overset{\text{2}}{1}$ January 8:11 A M Phillip Anthony Venable Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges St. Thomas More Hyattsville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
July 24, 1 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Director 213-62-5908 Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Baltimore 1 Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21205 Funeral 607 N. Robinson St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 X No Specify: black 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the 1 once. Aramark custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Thomas Edward Venable Estella Barnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Murray - sister Daniel Montane Smith/son 703 Fountiane Dr., Bullson NC 217893 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Nother (Specify) in State cemetery, crematory or other place) 1/28/2012 | Hanover MD <u>Ardent</u> 21. Signature of Funeral Service Licensee

Ronald S. Wade. Director

Phillip Weatherford per DVR 22. Name and Address of Facility State Anatomy Board Phillip Weatherford Fun. Home, 2431 Oliver St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a AZTERIO ECITACTO CARDIOVASCULAR disease or condition 2013 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any health sequential cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a nonsequence of): attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) ____ 23b Was decedent pregnant 23d Date of delivery in the past 12 months? Day 2 No 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End Stage Renal Disease I hemodialysis 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Avone Encephalopathy/ Respiratory Failup 24a, Was an Ventilaton Dependent certificate 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hystsville MD 20 781 DEVORE MI 4203 Queensbury 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

21215-0036

Baltimore, Maryland

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY LUTHRECIA WILEY 2012 1:05 a 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2900 St. Clair Dr. #109 Temple Hills Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X F Davs Hours Mar Ponth 2 ay, Year 970 578-88-4774 41 Yrs. VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Prince Georges Temple Hills 10e. Street and Number 10g. Citizen of What Country? 2900 St. Clair Dr. 20748 USA #109 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 yrs administrative GW University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Doris Hicks Lutheran Wilev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eriq Lewis - Son 920 Peabody St NW Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 1-19-2012 Alexandria, VA Signature of Puneral Service Licensee Marshariade Marchill Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ponset and Death months disease or condition resulting in death) Metastatic Lung Cancer Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Pregnant at time of death Month Day Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No

Physician/ Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

28a-f show

ō

23a

items

Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner munor or other traumatic event, the Medical Examiner munor or other traumatic event.

Department of Important: If it any injury or o oonce,

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

ρ

Completed

Be

2

MD

with the Maryland

Exami Physician/Medical Completed by Be မ

physician and the burial-transit attending p

been signed by the should be detached After this certificate has funeral director, page 2: To the Hospital or Attending Physician: The Certificate: thin 24 hours after death.

the Funeral Director: Af
impleted filled in by the fu death. Medical

Division of Vital Records, P.O. Box 68760

State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manne Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce

Washington, DC 20037

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Siegel, MD 2150 Penn Ave NW #1-100

31. Date filed (Month, Day, Year)

JAN 2 3 201

within 2

To the F

completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 30.per DVR, g923 1-23-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Tonya Wills A M 6:41 2012 January 18 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 8. Date of Birth (Month, Day, Sept 5 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 🗆 M 2 😿 F Hours 578-88-9470 42 Washington, DC Director Sept 1969 Usual Residence of Decedent or 28a-f shov should be filed within re...
I and Mental Hygiene.
I is marked other than "natural", or items 23a or zoe...
I is marked other than Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Hyattsville Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8604 21st Place 20783 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private 12th Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Galloway Sandra Bigelow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8604 21st Place, Hyattsville, Maryland 20783 Stanley Wills Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Landover, Maryland 01/24/2012 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 70 trophic Isteral Silens Immediate Cause (Final Onset and Death Physician empications disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the lineral director, page 2 should be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 LX Yes Hospital 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 XOOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident 1 Tyes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗌 Certifying Nurse Practioney: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sionalure and title of certifie 29d. Date signed (Month, Day, Year) 52326 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

State Registrar James Lightfoot JR.

20010 Century Blvd.

32. Registrar's Signature

Ste: 200 Germantown, MD, 20874

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WALLEN 3. Time of Death Physician/ 950 BY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 568 Pasture Brook Road United States Severn Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 1 □ M 2 🗗 F Months Davs Hours Min (Month, Day, Year, November 5 Director 226-52-0851 75 Virginia Usual Residence of Decedent ıral", or items 23a or 28a-f show I Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 V No Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 568 Pasture Brook Road 21144 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🔽 No Maryland 21215-0036 If Yes, Give Year or Dates "natural", 1 ☐ Yes 2 🙀 No White Specify: 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Andrew Jackson Hill Nancy Ellen Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Winters/Daughter 568 Pasture Brook Road, Severn, Maryland 21144 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State willis Cemetery January injury (4 ☐ Donation 5 ☐ Other (Specify) 2012 Blackwater, Virginia 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
Donaldson Funeral Home & Maryland 21113 21. Signature of Funeral Prvice Licensee 0375 MO1386 1411 Annapolis Road, Odenton, cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or compl shock, or hea ailure. List only on ause on each lin Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2-1 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1-Natural 5 Pending injury 1 Yes 2 No Accident Investigation 2 ☐ Acciden 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of centi 2012

State

30: Name and address of person

31. Date filed (Month,

HAE

Registrar

DEFENSE

MO21401

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 201 2-55 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore University Mary Land OI (enter If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) FEB 24, 1939 **Director** 1 M 2 XX 235.60.8708 72 Yrs 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2XX No MD FREDERICK FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1743 HEATHER LANE 21701 USA 11. Marital Status Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force ★★ 1 ☐ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify: WHITE If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 ASSISTANT NURSE HEALTHCARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ MALLIE STONE MARGARET WRAY STONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WARREN WATSON 663 EAST WATERSVILLE RD. MT. AIRY, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 XXRemoval from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) BLUE RIDGE MEMORIAL GARDEN JAN 25, 2012 BECKLEY, WV 21. Sig the of Fuperal Service Licen ee FINK FUNERALS HUME! P.A. T/A MARYLAND MORTUARY SUPPORT KAGREGORY FINE M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part 1 Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ UPIEW Gastrointestina disease or condition Medical resulting in death) **Examiner** troesophag Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and swongry CI the bunial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death Day 1 Yes 2 2 9 Unknown 2 🔀 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' Yes 2 No 2 🗌 No 1 🗌 Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 1 Npatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 🔀 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30 615 13 86 MD Jan, 21, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hashim 3253 Normandy woods assaw the Elicott Caty UD 31. Date filed (Month, Day, Year)

JAN 2 3 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month WELCH 1:45 AM 1CHASI Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death N/A JMMC BALTIMORE ノハ 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min 218-58-8643 Director 1 **X** M 2 □ F 63 Yrs Jan 12, 1949 Maryland show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore Maryland 1 🛂 Yes 2 🗌 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 3909 Third Street 21225 USA tal Hygiene. rd other than "natural", or item: event, the Medical Examiner m 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Viet Nam 1 ☐ Yes 2 X No Specify. Specify Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Oriole Park at Elementary/Secondary (0-12) College (1-4 or 5+) Seating Escort Camden Yards Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thaddeus Eugene Welch Mary Warkalonis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Hill (Sister) 3909 Third ST., Baltiore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Crownsville, Maryland Maryland Veterans Cemetery 4 Donation 5 Other (Specify) 1/25/2012 McCully-Polyniak Funeral Home, P.A. Signature of Funeral Service Licensee Kevin E Fcker 22. Name and Address of Facility MOO175 237 E. Patapsco Ave., Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Ph. sician/ disease or condition IdioDathic Pulmonary Medical resulting in death) as a consequence of) Examine Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 Yes 2 No 3 Probably 4 Unknown pluods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform After this certificate 2 No 1 Yes Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) P 1 Tyes 2 No Other 1. Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation 6 Could not be Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours after To the Funeral Direc determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

GR59,NE

MD

Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

2 3 12152264

ST

BALTIMORE

29d. Date signed (Month, Day, Year)

MD

2012

Please Type of ant in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:12 AM Medical <u>Helen Marie Abendschein</u> 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Heathand Overlea rs. 8. Date of Birth (Manth Jay, Year) 32 Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours Min. 219-10-4332 Director 79 Yrs Maryland Usual Residence of Decedent show 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 502 S. Kenwood Avenue 21224 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 X No 14. Race - American Indian. Black, White, etc. Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 🕅 Widowed 4 🗆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Il Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) n and Mental Hygien 7 is marked other t Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Williams Helen. Marie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 502 S. Kenwood Avenue Patricia M. Barzyk, daughter permit. Page 1 and 2 Department of Healt Important: If item 2 Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 01/24/12 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. EM 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death ue lo (or as a consequence of): disease or condition week Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 9 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by re, dementia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 2N 2 🗌 No 1 Tyes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) xaminer? ျ 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗌 Natural work? 1 Yes 2 No 5 Pending injury 24 hours after death. Funeral Director: Af 12/9/2011 7:004 Slipped out 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined nursing

Abendschein, Helen

within 2 To the F State

Medical

29a. Certifier

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Certifying Physician: To the best of my cowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Baltimore

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #21 Per FH G923 1/26/2011 JH. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aaron Alberts 01 2012 12:25PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 902 Princeton Terrace Glen Burnie Anne Arundel Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Hours Director 220-36-0733 1**X** M 2 □ F 70 07/15/1941 PA Usual Residence of Decede 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location notified at Director 1 Yes 2 No MD Anne Arundel Glen Burnie 5 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Examiner must be Completed by Funeral 23a 902 Princeton Terrace 21060 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 0 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
item 27 is marked other than "natural", or 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give "natural", White 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Technician Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ဂ Alberts traumatic Adam Catherine Sassano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Elnora Alberts / Wife 902 Princeton Terrace Glen Burnie, MD 21060 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 X Other (Specify)Entombment Cedar Hill Cemetery 01/24/2012 Brooklyn, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Selena Polasky M01479 per DVR Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Dea 3rain Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner a consequence of) as the burial-transi and Due to (or as a consequence of) attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) jo in the past 12 months? Month Day Year 2 No Yes be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 🗌 Yes 2 🗌 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide
Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Day, Year 29b. Signature and title of certifier 29c. License number ompleted cause of death (Item 23a) (Type, Print) 06 2

State Registrar

			For	State of	f Marylar		artment of H		and Me	ntal Hyg	iene		
			State Registrar			Cei	rtificate of I	Death	T -		eg. No. 2	012	01373
150	Physici	an	Decedent's Name (First, Middl	e, Last)					2.	Date of Deat Month	Day	Year	3. Time of Death
	/Media	al .		ugusto Jo		ralde	Alt. Oits Taura			anuary		2012 Inty of Death	11:25 A M
	Examir	er	4a. Facility Name (If not institution	3			4b. City, Town, or						
	Funeral		5. Social Security Number	kside Dri	7. Age (In yrs.	last birthday)	If Under 1 Year	vy Ch		Date of Birth (Month, Day,		ontgon 9. Birth	place (State or Foreign
2.9	Director		565-85-9870	1 XM 2 ☐ F	82	Yrs.	Months Days	Hours	Min. J	(Month, Day,	1929		gentina
	p.		Usual Residence of Decedent		140 50								
	arylar show d at	b	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 No
	he Ma 8a-f otifie	Director		ntgomery				y Cha	as e		0 000	/ / / / / / /	
	with t	Ë	10e. Street and Number				10f. Zip Code			1		of What Cou	
	eath	Funeral	6204 Broc	okside Dri	ve edent Ever in U	S 13	_	20815	nin? (Snecif	v Yes or No-		rgent: Race - Ameri	
10	fter d riter	F	1 ☐ Never Married 2 【X Mar	Armed Fo ried 1 ☐ Yes	rces? 2[X No		Was Decedent of H If Yes, specify Cuba				E	Black, White	etc.
036	ursa al'', o Exam	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	ve		1 XiYes 2 □ No	Specify A	rgent	inian	Spe	ec <i>ify:</i> Whi	t.e
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Deceden	it's Education est grade completed)		16a. Dece	dent's Usual Occup	ation	t of working			f Business/Ir	ndustry
21	ithin he. Med	nple	Elementary/Secondary (0-12)	College (1	I-4or 5+)	life.	kind of work done of DO NOT use retired		or troining		_	entini	
121	led w lygier her th		AT Falls to Nove (First Middle	4			Diplon		rio Nomo /F	First, Middle, I		ernmer	1t
and	d d d	Be	17. Father's Name (First, Middle,		1			ro. Mothe	,			,	
Maryland	hould d Me mark matic	ပ	HONOY 1 19a. Informant's Name/Relations	lo Alurral	ae	19h Maili	ng Address (Street	and Numbe		efina Route Number			in Code)
<u>≅</u>	Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than 'uty or other traumatic event, the Me		Gabriela Smit		r		Brookside						*
<u>5</u>	s 1 ar f Hea item othe		20a, Method of Disposition		20b. I	Place of Dispo	sition (Name of matory or other place	1	Date	е		on - City or T	
E E	Page lent o nt: If ry or		1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (5		State		ek Cemete	J	anuar 201	-	Wachi	ngton,	D C
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic		21. Signature of Funeral Service	Licensee	1210			_					Chase, Inc.
<u>m</u>			4 Guyel	inno	≥ M013		57 Wisconsi						
п			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that c t only one cause on e	aused the deat ach line.	th. Do not en	er the mode of dyin	ng, such as	cardiac or r	espiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	aa	Metasta	tic Lu	ng Cancer	<u>-</u>					3 Months
	/Medical Examiner		resulting in death)		or as a consec								
		<u></u>	Sequentially list conditions,	D	Brain M		ses					-	
	uted I Insit	Ë	cause. Enter Underlying Cause (Disease or injury	<									
ó	exectin and ial-tra	Examiner	that initiated events resulting in death) Last	Due to	(or as a consec	quence of):							
68760,	ficate be executed physician and s the burial-transit	dical		d									
89	rtifica ng ph	Med	IF FEMALE:										
Box	death certifii e attending p d for use as	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1□Live b	tcome pf pregn pirth 2 Feta		⊒Ectopic pregnancy	/			23d.	Date of deli	very Day Year
0.	0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregn 9□Unkno	nant at time of o	death 5	Other (specify)					Wollar	Day Tour
α.	The law requires that the de tte has been signed by the a bage 2 should be detached to	Phy		ons contributing to de	ributing to death but not resulting in the underlying cause given in Part I.						bacco use o	contribute to	the cause of death?
ds,	signe d be	d by		· ·		•	, , ,			1 🗆 Y	es 2□N	io 3∏Pro	bably 4 XUnknown
50	w require been si should b	Completed	-							24a. Was a	ın 2	4h Were au	topsy findings available
Be	The lav	ᇤ								autops perfor	sy med?	prior to c death?	ompletion of cause of
ta		a)	25. Was case referred to medica	ıl				26. Place	of Death ((1□ Yes Check only or	2KNo	1 □ Yes	2 □ No
>	ysic s ce direc	To B	examiner? 1 ☐ Yes 2 █️No	Hospital: 1 □ I	Inpatient 2] ER/Outpatier	nt 3 DOA Oth	or:		5 X Resid	.,	Other (Spec	rify)
Division or Vital Records,	<u>a</u> ± <u>a</u>		27. Manner of Death 1 XNatural 5 ☐ Pendir	28a. Date	of Injury th, Day Year)	28b. Time o	f 28c. Injur Wor	y at k?	280	d. Describe h	ow injury oc	curred	
Sio	Attending r death. ector: After by the fune	atic	2 ☐ Accident investi	gation				Yes 2□I	No				
Ξ	= e = =	Certification:	3 Suicide 6 Could 4 Homicide detern	nined 200. Flace	of injury - At h ing, etc. <i>(Speci</i>	ome, farm, st fy)	reet, factory, office		28f	Location (S City or Tow		umber or Ru	ral Route Number,
	Hospital		29a. Certifier 1 X Certifyii	ng Physician: To the	hast of my kn	nwleda deal	h occurred at the ti	me data an	od place, and	d due to the c	auco(c) and	d mannar as	etatad
	24 hc 24 hc Fun etely	Medical		Examiner: On the b									
	To the Hospital of within 24 hours aft To the Funeral D completely filled it	Me	29b. Signature and title of certifie				29c. Licens	e number		2	29d. Date si	gned (Month	, Day, Year)
			15.	(I IM)_			D001	4107		Janua	ry 18,	2012
٠			30. Name and address of person	•			·						
-			Bryan J. Arli				W, Suite	#817,	, Wash	ingtor	n, D.C	200	37
	Sta	ite	31. Date the Nanth Dan 199	32. R	legistra 's Sign	atire							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Alfred Ralph Barsotti 2012 8:45 A. M January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) November 28,1924 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**X** M 2 □ F 092-18-7035 87 Director New York, New York Usual Residence of Decedent 28a-f shov 10b. County with the Maryland traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Timonium 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? United States of America Funeral items 23a 12246 Roundwood Road Unit 705 21093 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò Completed by 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify 'natural", 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CPA Public Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Argina Colli Vittorio Barsotti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12246 Roundwood Road Unit 705 Timonium, Maryland permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mrs. Philomena Barsotti/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Janu^{Date}y Evans Funetal place) 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Forest Hill, Maryland Chapel - Bel Air 21. Signature of Fune al Service Licens 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 🗌 Yes 2 🗌 No Investigation within 24 hours after deat To the Funeral Director: completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier R043580 01-23-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS, 2300 DULANEY VALLEY ROAD CRNPTIMONIUM. MD31. Date filed (Month, Day, Year) State

Registrar

JAN 2

JANUARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death unk 1 Month Physician/ Willie Wallace 15^{Day} Baker 20 1º2 М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Pikesville 4609 Panacea Road Social Security Number If Under 1 Year I If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthp. Country) MD 1 X M 2 D F Days Min Months 212-42-9540 3 724 74 94 4 Director 67 Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f N/A Pikesville MD 1 🗆 Yes 2 🗙 No 10e. Street and Number 10f. Zip Code 21208 ō 10g. Citizen of What Country? ms 23a or must be r Funeral 4609 Panacea Road USA items ; Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. the Medical Examiner Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify "natural", Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland PHD 12th Human Resources Director other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie ည Baker Fairmean Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 Department of Health a Important: If item 27 is any injury or other trau 9050 Ironhorse Ln. Unt.115 Pikesville, MD Wallace Baker- Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place)
Garrison Forest 1/24/2012 OwingsMills, MD 22. Name and Address of Facility March F/H 1101 E. North Ave. Signature of Funeral Service Licensee Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a co burial-transi and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year bec the 9 Unknown signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵| Records, 1 Yes 2 No 3 Probably 4 Y Unknown Completed been s 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s has autopsy performed' death? this certificate 2 🗷 No 1 ☐ Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director, After thi completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work' 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examin On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check curtifying Nuse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the only one e cause(s) and manner as stated. 29d. Date signed (Month, Day, Year, 29b. Signatu title of 6

State Registrar 30. Name and add

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND ITEM#5perFH, G924, 2/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 21, 2012 9:38 A John Wiley Bowling Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Young at Heart Assisted Living Harford Joppa 2524-32-4335 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Months Days Hours Min. Virginia **Director** 33 4335 83 Sep. 928 Usual Residence of Decedent show ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Marvland | Harford Abinadon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4009 East Baker Ave. 21009 USA items 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. ò þ 1 ☐ Never Married 2 🔀 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify. Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Pipe Manufacturer Steel Cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o မ Owen Anderson Bowling Bertha Imagean Roten traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i Beth A. Higgins / Daughter 24705 E Montiego Road, Hollywood, MD 20636 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 1-24-2012 Towson, Maryland 22. Name and Address of Facility 21. Signatur Ju Funeral Service Licenses McComas Funeral Home, P.A. 120 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Principalic curce Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death the 9 Unknown Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1.24 hours after death.

• Funeral Director. After this certificate has autopsy performed? Yes 2 No 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 XOther (Specify) Assisted Hospital 2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Living 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one)

J

29b. Signature and title of certifier

31. Date filed (Month, Day,

Down 5

JAN 2 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W.MA-Pha.

Registrar's Signature

29c. License number

037295

Beldir m

29d. Date signed (Month. Dav. Year)

		1 - State Registrar	partment of Health and Mertificate of Death	Reg. I	0010	01377							
Physicia	an	Decedent's Name (First, Middle, Last) Thomas Vincent Bilek	2. Date of Death Month Innuary	22 Year 2012	3. Time of Death 2:40 A M								
/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	2.40 A							
Examin	er	Brighton Gardens	Bethesda		Montgomery								
uneral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 02/25/192	9. Birth	place (State or Foreign							
irector		217-18-9528 1X□M 2□F 89 Yrs.	22 N	Maryland									
w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		1	IOd. Inside City Limits							
f sho	to	NC Orange	Chapel Hill			1 □Yes 2X No							
r 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?							
23a o		2 Davis Love Drive	27517		USA								
ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ								
or it	by Fi	12√ Never Married 2 Married 1 Married 2 Married 1 Marri	1 ☐Yes 2X☐No Specify:		Specify:								
atural PLE	edk		cedent's Usual Occupation	T 16b.	W. Kind of Business/In	hite _{dustry}							
Medic	plet	(Specify only highest grade completed) (Gir	ve kind of work done during most of work . DO NOT use retired)			/							
er th	Completed	12 5+	School Teacher		Educat	ion							
d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	len Surname)								
narke	ဠ	Joseph Bilek		Bozena									
7 is r traur			iling Address (Street and Number or Run Davis Love Drive, Chapel		•	o Code)							
tem 2					Location - City or To	own, State							
Department of result and wenterful typere. In particular it is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, Its Macinal Examination must be realished at once.		r Buriai 2 Defermation 3 Harmoval from State	i	/2012	Beltsville	MD							
porta y inju	1	21. Signature of Funeral Service Licensee	22. Name and Address of Facility										
8 5 5		Dorota Marshall Double Chartell Maryland Cremation Services, PO BOX 1413, Baltimore, MD 21203											
sician and edical e prival-transit	cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi		B ☐ Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Ye									
signed be de	Ω	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?									
hould	eted		1 Yes 2 No 3 Probably 4 Unknow										
tificate has or, page 2 s	e Completed	25. Was case referred to medical	GC Place of Park	24a. Was an autopsy performed 1 Tyes 2 Type (Check only one)	prior to co	opsy findings available ompletion of cause of							
direct	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	Other:	me 5 Residence	6 DOther (Speci	ASSISHED							
or: After th he funeral	Certification: T	27. Manner of Death 1. Repending 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how injury occurred									
ral Direct		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	City or Town, St	(Street and Number or Rural Route Number, own, State)									
he Fune pletely fi	Medical	29a. Certifier (Check only one) 11 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due t	stated. to the cause(s)							
To t	Σ	29b. Signature and title descriffier	29c. License number 3691		Date signed (Month,	3. 2012							
		30. Name and address of person who completed cause of death (Item 23a) (Type A) AY REDDI, MD., 32.00 To	e, Print) Ler Cecks Bival, 5	He 110, P	akille	1 40							
Stat Registra		JAN 2 4 2012 Server 32. Registrar's Signature 32. Registrar's Signature	*										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 20 2012 January Diane Brown 5:45 Α /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 2312 Carter Avenue Calvert Dunkirk If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, Year 04/25/1954 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2X□ F 217-60-9843 57 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director X□Yes 2□No Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 658 Field Road 20657 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examinat must any injury or other traumatic event, the Medical Examinat must any injury or other traumatic event, the Medical Examinat must any injury or other traumatic event, the Medical Examinat must any injury or other traumatic event, the Medical Examinat must any injury or other traumatic event, the Medical Examination of the must be a first and the must be a first and mus USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No ģ Specify. Specify: 3 Widowed 4 Divorced Year or Dates: Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Brown ٩ Hilda Chew 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine A. Brown / Sister PO BOX 42, Sunderland, MD 20689 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Chesapeake Crematory -1/24/2012Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 11/16 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami bunal-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p for use as t IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 1 □Yes 2 No 2 🗆 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: After this of funeral direction 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) Brother 5 Certification: To 27. Mangler of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Mouse 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. iours after death.

neral Director: A
filled in by the fu 1 □ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of erson who completed cause of death (Nem 23a) (Type, Print) ill 238 ONGIMEN 6 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Riverview Nursing Center Baltimore Social Security Number If Under 1 If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Year 8. Date of Birth **Funeral** 1 🗆 M 2 🖺 F Days Hours Min M88/14/1935 Maryland 213-30-3195 76 **Director** Yrs 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 2760 Moorgate Road 21222 **USA** 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed 3 X Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Optician Healthcare 12 Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) ပ္ Harry Bailey Glenna Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tran Charles Thomas Chopper, JR. / Son 2760 Moorgate Road, Baltimore, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 1/21/2012 Beltsville, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause or each line. oroximate al Between et and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or se a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed and-tran-Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) the 1 ☐ Yes 2 ☐ Unknown Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate has 2 No Yes 2 N 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other 1 Tyes 2 NO ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: Director: After 1 Natural 2 Accident (Month, Day, Year) 5 Pending work 1 Yes 2 No Investigation Suicide 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined hours after within 24 hours a

To the Funeral I

completely filled Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one of death (Item 23a)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 01380 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -Month Florence Estelle Buschena Medical avo 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Plata Conter 0 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛛 F Months Days Min Hours (Month 1924) 1924 Massachusetts **Director** 022-44-3236 87 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD Charles Cobb Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17316 Vickers Drive 20625 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Did Not Work N/A 3 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Arnold J. Buschena Estelle Mathewson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Lillian Rand / Sister 501 Regency Drive, Charlotte, NC 28211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/24/2012 Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ LOSTRIDIUM DIFFICILE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day signed by the a Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CHRONIC OBSTRUCTIVE PULMONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL FIBRILLATION 24a. Was an cate has autopsy performed Yes 2 ANEMIA certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ဍ 1♥ Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 Tes 2 No Accident Investigation after deatl Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed file 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHAKAR DEVATHI M

DHMH 17 Rev 7/2009

State Registrar 32. Registrate

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1633 M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Country Brazil Min (Month 13/1924 1 🗆 M 2 🔭 F 173-22-8828 87 Director or 28a-f show 10b. County with the Maryland 10a. State 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director Yes 2 No MD Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 321 Hillsmere Drive 21403 **USA** permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 2 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed 3 Widowed 4 Divorced Specify White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adam Martin Nettie Moser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Bates / Husband 321 Hillsmere Drive, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 1/23/2012 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ARI Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transi FROS CLENOTIC Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE f yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Completed the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' To the Funeral Director: After this certificate 2 🗌 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 1 Yes 은 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗌 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 (Check Certifying Nurse Practition er: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one ignature and title of o

State Registrar 31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

214

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:37 R M 29mp Japya 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GRO Bussie Josef paltomore WASHINGTON A) redical Hoter Social Security Number 6. Sex If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, **Director** 216-70-2873 1 🛛 M 2 🗆 F 55 Yrs. 02/28/1956 Maryland Usual Residence of Decedent 28a-f show with the Maryland be notified at Director 10a. State 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🗓 No MD Anne Arundel Glen Burnie 10e. Street and Number ò 10f. Zip Code 10a. Citizen of What Country? Funeral 23a604 Tranton Road 21061 U.S.A. items ? permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Completed 3 Widowed 4 Divorced Specify. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer 10 Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Biller Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Brenda Biller / Wife 604 Tranton Road Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its any injury or of once. 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 01/20/2012 Glen Burnie, MD M01479 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD 11 Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-transi Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for igned by the at be detached for Pregnant at time of death Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> should Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autops perform death? 1 Yes 2 No Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 2 No ည 1 npatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) oncertifier 29b. Signaturo 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

0

32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type

() (

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 01383 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:25 P.M. Formis Harry Berman, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Washington Medical Center Anne Arundel Glen Burnie 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) **Director** 212-22-1438 1 X M 2 □ F 85 Yrs. Sept. 7,1926 Maryland Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2 XNo 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 1500 Long Point Road 21122 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. ed other than "natural", or iter event, the Medical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced BERMEN 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 I alth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Chauffer Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ other traumatic Morris Berman Annie Barnhouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai Harry Berman, Jr. / Son 1500 Long Point Road, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Glen Haven Cemetery Jan. 24,2012 Glen Burnie, Maryland 21. Signature of Fund al Service Licensee 22. Name and Address of Facility
AMBROSE FUNERAL HOME OF LANSDOWNE
2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? Year Month Dav Pregnant at time of death 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s certificate has perform Yes 2 No 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c ျု 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 1 Natural 2 Accident (Month, Day, Year) 5 Pending injury nours after death.

neral Director: Aff
filled in by the fu 1 ☐ Yes 2 ☐ No М Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe. 30. Name and of person who completed cause of death (Item 23a) (Type, Print). Date filed (Month, Day, Year) 32. Registrar's State

DHMH 17 Rev 06-2011

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State		State	of Marylan		ertificate			ITIU IV	ientai ny	•	001	0	0120	21.
		Registrar 1. Decedent's Name	e (First, Middle	e, Last)			erincate	טוט	eaur		2. Date of D	Reg. N			3. Time of Deat) \
/sicia		John	, ,	Richard	Bert	ani					January	1.	8, 2012	ar 2	1:00 P	
Medic camin		4a. Facility Name (if				QI II	4b. City, To	own, or l	Location of	Death	<u>oaridar y</u>		lc. County of D			
		104 La	a Paix	Lane				Tow	son				Balt:	imoı	ce	
neral		5. Social Security No		6. Sex	7. Age (In yrs. I	ast birthday,		Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bi		g.	Birthpl Countr	ace (State or Fore	eign
ctor		116-32-8 Usual Residence		1 🖁 M 2 🗆 F	88	3 Yrs.					July 1				aly	
at	or	10a. State	10b. County		10c. Cit	y, Town or L	ocation							10	d. Inside City Lin	nits
raumatic event, the Medical Examiner must be notified at	Director	Maryland	Balti	imore		Tows	on								1 🗌 Yes 2 🛚	No
oe uc		10e. Street and Nun	nber		-		10f. Zip C	ode				10g. (Citizen of What	Count	ry?	
ieni	Funeral	104 La F	aix La	ne			2	2120	4				U.S.	Α.		
iner		11. Marital Status1 Never Marri	₩1	Armed F	edent Ever in U.S orces?	3. 13	 Was Deceder If Yes, specify 	nt of His / Cuban	panic Origi , Mexican,	in? (Spec Puerto F	cify Yes or No Rican, etc.)	-	14. Race - A Black, W			
xam	d by	3 Widowed		If You Gi			1 🗆 Yes 2	X No	Specify:				Specify: Ta	hit	P	
Ca	lete	/2		nt's Education		16a. Dec	edent's Usual (Occupat	tion			16b.	Kind of Busine			
	Completed	(Spe Elementary/Seco			1-4 or 5+)	life.	e kind of work o DO NOT use re	etired)		of Workir	ng					
	Be C			3		Ra	adio Of					U.S. Merchant Marine				5
	일	17. Father's Name (I	⊦ırst, Middie, L L€	ŕ	ertani				18. Mother		(First, Middle arbara		n Surname) Cucc	hi		
		19a. Informant's Na			CI Carri	10b Mai	iling Address (S	Stroot or	ad Numbor						ada)	
		Lisa Bei		Wife			La Pai:								oue)	
		20a. Method of Disp	osition		20b. F	Place of Disr	nosition (Name	of	1		ate	ī	Location - City	or Tov	/n, State	
, j		1 ☐ Burial 2 l 4 ☐ Donation		3 □ Removal from Eartoombmer	n State DU E 1 t M	emori	Valley™ al Garc	lens	1	-21-	-2012	Ti	monium	Ma	aryland	
any injury or other traumatic event, the Medical once.		21. Signature of our				2	22. Name and	Address	of Facility	Ruc	k Tows	son	Funera.		ome, Inc	•
g g		1050 York Road Towson, Maryland														
н		shock, or heart failure. List only one cause on each line.										Approximate Interval Between				
an/ cal		Immediate Cause (Final disease or condition resulting in death) a. Stage IV Congstwe Heart failure Imm												مراما مراما		
cai ier		Due to (or as a consequence of):														
Ä	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):														
	xaminer	cause. Enter Underlying Cause (Disease or injury that initiated eventions														
	ш	resulting in death) Last Due to (or as a consequence of).														
	Jica			L d.										\perp		
	Physician/Medical	IF FEMALE:														
	ian/	23b. Was decedent in the past 12 r			eath 3 Dectopic pregnancy						23d. Date of delivery Month Day Year					
	ıysic	1									Wiena		ouy rour			
		Part II. Other signif	icant conditio	ons contributing to	death but not res	ulting in the	underlying cau	use give	en in Part I.		23e. Did	tobacco	use contribut	e to the	cause of death?	,
	sq pa	J.	arkin	tonism							1 🗆	Yes	No 3 [Proba	ably 4 🗆 Unkno	own
	Completed	A	trust	Fibrille	ten						24a. Was				sy findings availal	
	E O		11	0							auto perf	ormed?	deatl	1?	pletion of cause	OT
	Bec	25. Was case referre	ed to medical					26. Plac	ce of Death	(Check			10	103 2	. 🗆 140	
	2	1 🗆 Yes 2	No	Hospital:	Inpatient 2 🗆	ER/Outpation	ent 3 DOA	Other	: 4 🗆 Nur	sing Hor	ne 5 PRes	idence	6 Other (S)	pecify)		
	ate:	 Manner of Death Natural 	n 5 ☐ Pendin	28a. Date (Mor	of injury oth, Day, Year)	28b. Time of injury	1	. Injury a work?			8d. Describe	how inju	ury occurred			
	Certificate:	2 ☐ Accident 3 ☐ Suicide	Investig	gation	e of Injury - At ho		M track factors o		es 2 🗆 N	-	06.1			D 15		
		4 ☐ Homicide	determ	ined build	ing, etc. (Specify)	treet, lactory, o	nice		2	City or To		nd Number or te)	Hurai F	toute Number,	
	ical	29a. Certifier 1	Certifying	Physician: To the	pest of my knowl	edge, death	occurred at th	ne time,	date and p	lace, an	d due to the o	ause(s)	and manner as	stated	d.	
	Medical	(Check 2	Medical E	xaminer: On the ba Nurse Practitione	sis of examinatior	and/or inve	stigation, in my	opinion	, death occ	urred at	the time, date	and plac	ce, and due to t	he caus	se(s) and manner s	stated.
	-	29b. Signature and t			. 1			icense r		a			ate signed (Mo			
		1/2	weres)	still NI	4		<	1/7	200	1			1/2	10	10/2	
		30. Name and address	ssplatin,	white Doleted 3	801 de Et de R	²R⁄aVê	rfrin Blv d.	. Ва	ltimo	re,	Md 21	1239	//			
				1 1												

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

JAN 2 4 2012

22. Registrar's Signature Barkel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Bridges $8^{
m I}$ Elizabeth January 2012 10:23 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8401 Kellogg Court Lutherville Baltimore Social Security Number 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days 216-12-5181 Director 1 M 2 X F 92 Oct. 25, 1919 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director MD. Lutherville Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 8401 Kellogg Court 21093 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 10College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Luther E. Tresler Ada E. Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela J. Bridges/ Daughter 8401 Kellogg Ct. Lutherville, MD. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cometery, crematory or other place)
Druid Ridge Cemetery 1-23-12 1 X Burial 2 Cremation 3 Removal from State Pikesville, MD. 4 Donation 5 Other (Specify) 21. Signature of Fun ral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate

Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Box 68760 as the t attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has performed 2 No Yes 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this of Death 27. Mann 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? death. 1 Yes 2 No 2 Accident Investigation 3 🔲 Şuicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after determined To the Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and ti ne and address of person who completed cause of death (Item 23a) (Type, Print) TEXAS STATION CT.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elsie Bayer January 3:45 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center <u>Annapolis</u> Anne Arundel Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 213-09-5121 Director 1 🗆 M 2 🔭 F 92 Aug 3, 1919 Maryland or 28a-f show 10a State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Anne Arundel 1 Yes 2 No Annapolis 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2562 Carrollton Road 21403 U.S.A. death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 💢 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 X Widowed 4 Divorced Specify: White Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Markiewicz Salome Health and Ntem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 2562 Carrollton Rd., Annapolis, Ted Bayer-son MDImportant: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sacrd Heart of Jesus 1/24/12 Dundalk, MD Signature of Funeral S vice Licensee William G. Dau 22. Name and Address of FacilitRuck Towson Funeral Home, Inc. <u>1050 York Rd.,</u> Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician! disease or condition resulting in death) Medical [']Examine Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 2 Accident
3 Suice 1 Natural 5 Pending 1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [only or Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated who completed cause of death (Item 23a) (Tyr State 2 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day 1/20/2012 **Physician** P^{M} 5:50 Shirley J. Burkowske /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Catonsville Commons Catonsville Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 □ M 2 🕱 F 81 Director 053-24-8430 6/25/1930 PA Usual Residence of Decedent 10a State 10b County 10c City Town or Location 10d Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Experiment neat to notified Director MD 1 ∑Yes 2 ☐ No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 820 S. Caton Avenue 21229 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel 1 ☐ Never Married 2 🔀 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Richter Inez Dadev ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traun once. 3 Reynolds Street, Bronx, Mew York 10464 Leonard Simoncek / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Ponetion 5 ☐ Other (Specify) 1/23/2012 Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** cancer months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinite late cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed for use as the burial-trans and resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnag 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 mor Year Day 5 Other (specify) P.O. I ed by the a detached f 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 ☐ Yes 2 No ospital or Attending Physician: hours after death. 25. Was case referred to medical examiner? Be 26. Place of Beath (Check only one) Other: 1 ☐ Yes 2 **V**No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Yes 2 No neral Director: / 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 29a, Certifier 1 Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature a

Registrar

State

Name and address of person

Year)

31. Date filed (Month, Day, JAN 2

adion Blv4

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Phyllis L. Bain Januar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Saint Joseph Medical C 10 If Unde 8. Date of Birth Birthplace (State or Foreign Country) last birthday If Under **Funeral** Hours (Month, Day, Year) 034 12 5118 **Director** 1 🗆 M 2 🔀 F 88 Yrs 7-13-1923 CT Usual Residence of Deced 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. if item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Baltimore Towson 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1055 West Joppa Road #608 21204 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lloyd W. Beach Marion C. Coogan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alison Bain Zuzak/Daughter 4982 Threshfield Court Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō ± 5 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Garrison Forest Vet. 1-27-2012 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of) sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No detached for Day Year Pregnant at time of death Unknown 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has autopsy 2 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28c. Injury at work? Manner of ath 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. witiging Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

7601 Osler Drive Towson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Utrschneider, M.D.

			For State	State of	Marylan				nd Mental H	lygien	e	0 010	200
			Registrar	1 204)		Cer	tificate of L	Death		Reg. N	<u>. 201</u>	2 013	305
	Physicia	n/	1. Decedent's Name (First, Middle Alo:		Brucl	kbauer			2. Date of Month		ay 2012	3. Time of D	
	Medic		4a. Facility Name (if not institution.				4b. City, Town, o	Location of	Janua				P ^M
	Examin	er	Potomac Valley		ockvil		44	c. County of D	tgomery				
	Funeral		5. Social Security Number	6. Sex 7.	. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24	4 Hrs. 8. Date of	Birth	9.	Birthplace (State or	Foreign
	Director		578-02-7988	1 X M 2 □ F	64	Yrs.	Months Days	Hours	Min. June	Day Year 22,	947	Country) G ermany	
	D wo	_	Usual Residence of Decedent 10a. State 10b. County		10- 0%	y, Town or Lo				-		1,01,4,11,00	
	ırylan t-f sh ied a	cto			Toc. City	y, lowil or Lo						10d. Inside City	
	or 28a	Director	Maryland Montgomery 10e. Street and Number				10f. Zip Code	vy Cha	ase	100 0	itizan of Mhat		2 110
	vith th	ral	4550 N. Park		20815		109.0	og, Citizen of What Country? Germany					
	eath v	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S	6. 13. V			n? (Specify Yes or N Puerto Rican, etc.)	10-		merican Indian,	_
9	ter de , or it	by	1 Never Married 2 🔀 Marr	ried 1 Yes 2					Puerto Rican, etc.)		Black, W	hite, etc.	
3	ursat tural" alExa	Completed	3 Widowed 4 Divorced	real of Date	es.	3-27-5-	☐ Yes 2 🔀 No	Ѕреслу:			Specify:	White	
7	72 ho "mat edic	aldı	15. Deceder (Specify only highe	nt's Education est grade completed)		(Give i	lent's Usual Occup kind of work done o		of working	16b. I	Kind of Busine	ss Industry	
2	ithin ene. thar	Con	Elementary/Seconday (0-12)	College (1-4	or 5+)	life. Di	O NOT use retired) Chauffe u			Cox	man Em	hacay	
מ	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, L				Ghauffet		's Name (First, Midd			Dassy	
Maryland 21215-0036	be fil lental rked tic ev	To	Alois	s Bruckbaue	er				Rosa	•	,		
aZ	should be file and Mental Fis marked or raumatic eve		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	g Address (Street	and Number	or Rural Route Nun	ber, City o	r Town, State,	Zip Code)	
	of Health and Ments of Health and Ments fitem 27 is marked rother traumatic e		Karen Bruckba	uer / Wife		4550 1	N. Park Ave	nue Apt	t. #T208, C	h e vy (Chase, Ma	ryland 2081	L5
Baltimore,	ge 1 and the street H items or oth		20a. Method of Disposition 1 ☐ Burial 2 🏻 Cremation	3 ☐ Removal from S	tate 20b. P	lace of Dispo emetery, cren	sition (Name of natory or other plac	e) J:	anuary 21	20c. l	_ocation - City	or Town, State	
E	t. Page 1 tment of tant: If it ijury or o	1	4 Donation 5 Other (S	Specify)			natory or other place omery orium, In	ic.	2012	Bet		Maryland	
Ra	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service L	icessee n	M0136	50 Ro	Name and Address Dert A. Pur 557 Wiscons	nphrey l in Aven	Funeral Hom ue, Bethesd	e/Beth a, Mar	esda-Che yland 20	vy Chase, I 814-3501	inc.
			23a. Part 1. Enter the disease, or shock, or heart failure. List o			n. Do not ente	r the mode of dyin	g, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between	een
~	Physician/	G 1	Immediate Cause (Final disease or condition	Enc	ephalo	pathy						Onset and De	
	Medical Examiner		resulting in death)		as a consequ								
		er	Sequentially list conditions,	b	as a nonsequ	boes one							
	ted nsit	Examiner	to by leading to in a redicte cause. Enter Underlying Cause (Disease or injury										
	axecu n and ial-tra	Exa	that initiated events resulting in death) Last	c. Due to (or	as a consequ	ence of):							
2	r requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical	,	d									
200	tificat ng ph as th	Mec	IF FEMALE:										
S X	th cer ttendi or use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnanc	ey .		- 1	23d. Date of					
POX	e dea the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnal 9 ☐ Unknov	nt at time of d wn	leath 5∟	Other (specify) _			-	Month	Day Ye	ai
у. О	hat the ed by detac		Part II. Other significant condition	ns contributing to dea	th but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Di	d tobacco	use contribute	to the cause of dea	ath?
'n.	irres t sign Id be	d by							1	Yes 2	X No 3 □	Probably 4 🗆 Ur	nknown
0	v requ	olete							24a. W	as an	24b. Were	autopsy findings av	ailable
Vital Records,	he lav te has age 2	Completed							pe	itopsy erformed? es 2 💢 N	death	to completion of cau ? Yes 2 □ No	use of
<u>.</u>	ian: T rtifica stor, p	BeC	25. Was case referred to medical examiner?	#			26. Pl	ace of Death	(Check only one)	s ZLALIN	10 10	res 2 🗆 NO	il.
=	hysic nis ce I direc	10	1 X Yes 2 □.No		patient 2 🗆	ER/Outpatien	t 3 🗆 DOA Othe	er: 4 🂢 Nurs	sing Home 5 🗆 Re	esidence	6 ☐ Other (Sp	ecify)	
IVISION OF	ing P	ate:	27. Manner of Death 1 ☒ Natural 5 ☐ Pendin	28a. Date of (Month,	injury Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describ	e how inju	ry occurred		
0	ttend death stor: / the f	Certificate:	2 Accident Investig	not be	mo form etre	M 1 L	Yes 2 N		· (C++		Dural Davida Musika		
Ĕ	lor A after Direc		4 Homicide determine	ined building	et, factory, office			own, State		Rural Route Number	г,		
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.									stated.	
	he Ho in 24 he Fu	Med		xaminer: On the basis Nurse Practioner: To									ner stated.
29b. Signature and title of certifier							number		29d. Da	ate signed (Mo	nth, Day, Year)		
			funn	N July	.0		D00	68890		Ja	nuary	17, 2012	
			30. Name and address of person v					116	Marriand	20251			
	Stat		Summit Gupta, 31. Date filed (Month, Day, Year)		istrar's Signati	ure -	e, KUCKVI	rine, I	rar y rand	2000			
	Registra		IAN 9 4 2012	house	1. 100	Me							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Clara Mae Coleman 4:40 P.M 21,2012 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Hosice Timonium Baltimore County Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) Days Hours 301-18-9419 **Director** 1 M 2 XF 88 Jan.11,1924 Milan,Ohio ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 110 Gallewood Road 21093 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. by 1 Never Married 2 Married Yes 2 X No Yes, Give 1 Yes 2 No Specify. 3 XWidowed 4 Divorced Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore Federal College (1-4 or 5+) **N/A** Elementary/Secondary (0-12) Mortgage Analyst Savings & Loan Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Moreland Mary Wagoneer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Mary Alice Bond (Daughter) 110 Galewood Road Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Exars fure al Crapel and Cranation Services, Inc. (Harford County) 1 Burial 2X Cremation 3 Removal from State Tuesday 4 ☐ Donation 5 ☐ Other (Specify) Jan. 24, 2012 Forest Hill, Maryland 21. Signature of Funeral Service License-Jeffrey L.Gair, Sr. CFSP 22. Name and Alternatives Funeral and Cremation Center, P.A.

Whys. J. Gair, Sr. CFSP 22. Name and Alternatives Funeral and Cremation Center, P.A.

2325 York Road Timonium, Maryland 21093-2215 vart 1. Enterphe disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ END STAGE DEMENTIA disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 month 1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) ____ Month Day Year Pregnant at time of death 9 Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 2 No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗶 No Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tes 2 X No မ 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best stray numbers death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar

ANUARY

DHMH 17 Rev 06-2011

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES,

31. Date filed (Month, Day, Year)

2012

TIMONIUM, MD 21093

Please amend
Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2:250 M 01 Medical 1'7 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arnold Anne Arundel 1475 Falcon Nest Court 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min 217-32-8118 Director 1 🗆 M 2 🌠 F 75 Yrs Feb 5, 1936 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner πust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A 1 X Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 1401 S. Carey Street 21230 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 ☐ No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Professional Server 11 Private Club Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Germroth Josephine Holden .. Page 1 and 2 should tment of Health and N tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Almony, Daughter 6421 Flintlock Court Sykesville, Maryland 21784 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of h Important: If ite 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) injury or 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/20/12 Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor Remarkable Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 any roman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition UnlLnown Medical resulting in death) sequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed certificate 2 🗌 No Yes 2 No 1 🗌 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 \square Nursing Home 5 Thesidence 6 \blacksquare Other (Specific grandson's 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DQA After this 28a. Date of injury (Month, Day, Year) residence 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 052756 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huy ANNAPOLE MD 21401 MO Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012

For State Registrar Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 2012 4:35 P M ANUARY 18. ROBERT THOMAS CARLETTI Medical 4a. Facility Name (if not institution, give street and number) 4b City Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER HARFORD FOREST HILL 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) Days Hours Months **Director** 213–20–9678 Usual Residence of Decedent 1 X M 2 - F Yrs 85 Feb. 14, 1926 Maryland 10a. State 10d. Inside City Limits 10b. County death with the Maryland 10c. City. Town or Location Director notified 28a-f 1 Yes 2 X No Maryland Harford Forest Hill 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ō ms 23a or must be 1977 Esther Funeral Court 21050 United States ural", or items ? I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WW II If Yes, Give -Year or Dates. Black, White, etc. by 1 Never Married 2 K Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiens and If flem 27 is marked other than "natural", or ant If item 27 is marked other than "natural", or any or other traumatic event, the Medical Examinary or other traumatic event, the Medical Examinary Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **5+ B&O** Railroad Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Levino Carletti Beatrice Pelliceia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1977 Ester Court Forest Hill. Maryland 210 19a, Informant's Name/Relationship (Type, Print) Mrs. CHarlotte Carletti / Wife Forest Hill, Maryland 21050 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan Zf, cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Bel Air Mem. Gardens 2012 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service—Bel
3 Newport Drive Forest Hill, Maryland 21050 Air Da Z 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ lou ca disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury the burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ģ Year Month Day Pregnant at time of death Yes a I Inknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No certificate 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) 24 hours Medical 29a. Certifier 互 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 3732299 January 20, 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 DR. DAVID DUNN 31. Date filed (Month, Day, Year) Registrar's Signat State JAN 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-00536 State of Maryland / Department of Health and Mental Hygiene Richard Norman Clark 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 19, 2012 1148 hrs **Medical Examiner** Richard Norman Clark 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Overlea 9 E. Overlea Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Days Months Hours Director Country) Maryland 215-30-9708 75 OCT 9. 1 X M 2 F Yrs 1936 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. Count 1 Yes 2 X No or 28a-f show Baltimore Baltimore iten 27 is marked other than "natural", or items 23a or 28a-f sho. traumatic event, the Medical Examiner must be notified at once. rmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland epartment of Health and Mental Hygiene.

iportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho lary or other traumatic event, the Medical Examina. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 E. Overlea Avenue 21206 IISA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 Married 2 X No Yes 1 Yes 2 X No specify: Specify: White 3 Widowed 4 X Divorced If Yes, Give Year 至 r Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 8 Typesetter Printing 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas H. Clark Dorothea 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ Cynthia Lynn Clark, daughter Nottingham. Castell Court MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD Metro Crematory, Inc. 01/21/12 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of MD, George MacNabb 299 Frederick Road Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial - transit Physician/Medical ■ AMENDED 24a, per me, g925 3-30-12 sm UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of deliven IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Month Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ٥ 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been ifuneral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 No X Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year 27. Manner of Death Certification 1 V Natural 1 Yes 2 No Director: d in by the f 5 | Pending 2 Accident completely filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after o Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier o a O.C.M.E. January 20, 2012 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Ling Li, MD Assistant Medical Examiner 32. Registra 31. Date filed (Month 4 2012 Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene per me, g923,01/27/2012dhb Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Oletha 11:54 AM 2012 Januari Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Multimedical Center Baltimore TOWSON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 2818 Director 1 □ M 2 🔀 F 76 SOUTH CAROUNA 09-05-1935 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral DRUID HILL AVENUE 21217 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: BLACK Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PARENT LIASON 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mood WALTERS KosA HNDREWS WILLIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORTHWOOD BALTO, DAUGHTER ATHERINE MD, 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) BANMOVE, MD 4 ☐ Donation 5 ☐ Other (Specify) WoodLAWN Cemetery 2012 GREENE FUNERAL SUS 22. Name and Address of Facility VAUGHN 21. Signa, re of Funera Service L censee ROAD. MO-21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final "Physician/ LLrosepsis hours-days disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of): Cause (Disease or Injury that initiated events and burial-trai Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death ned by the at detached for 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Recurrent tracheobronchitis 1 Yes 2 No 3 Probably 4 Unknown Completed Cerebrovascular intracranial hemorrhage (right-fronto parietal) 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Advanced chronic obstructive pulmonary disease To the Hospital or Attending Physician: The 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1X Yes 2⊞No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Exertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie R097104 Varuary 20,201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center

Registrar

31. Date filed (Month, Day, Year,

JAN24

DHMH 17 Rev 06-2011

7700

York Road

Towson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BETH WILDS CARSON January 22, 2012 1:17P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death GILCHRIST HOSPICE CENTER Baltimore County Towson Social Security Number **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 X F 219-58-3321 ^{rea}1944 **Director** Jan 30 Maryland 67 Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Baltimore County 1 ☐ Yes 2 🛣 No Reisterstown 10e. Street and Number 10g. Citizen of What Country? Funeral 412 Valley Meadow Circle, T-1 21136 USA "natural", or items edical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed White th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Marketer / Sales Energy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Howard Ferdinand Wilds, Jr. Virginia Hughes Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Michael Burke Carson (Son) 65 Old Long Ridge Road, Stamford, CT 06903 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Green Mount Crematory 1/26/2012 Baltimore, Maryland 21. Signay will be for an au Mincan Address fed FFELD FUNERAL HOME INC 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final lare Onset and Death Physician/ CAYCUNOMA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, il any mading activities and cause. Enter Underlying Cause (Disease or linjury Die to (or as a consequence of). The law requires that the death certificate be executed signed by the attending physician and defached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24a. Was an 24b. Were autopsy findings available has page 2 autopsy prior to completion of cause of death? certificate 2 No Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: 1 Yes 읻 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence accie this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 \(\sum \) Yes 2 \(\sum \) No ☐ Accident ☐ Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one und son who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

701

M. Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G925 3/15/2012 JH State of Maryland / Department of Health and Mental Hygiene? 0 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Richard H. Cruise January :35A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel . Social Security Number 034–32–9808 If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Sept. Day, Year ,1945Massachusetts 1 😾 M 2 🗌 **Director** 66 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 402 Silverleaf Ct., Apt. D 21061 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. \$ 1 Never Married 2 Married Yes Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 Divorced Completed Specify: White 162-186 Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Army - Ret. Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edward John Cruise Helen Frances Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Silverleaf Ct., Apt. D, Glen Burnie, MD 21061 Shirley Cruise / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place) January 2012 Metro Crematory, Inc. 4 ☐ ponation 5 ☐ Other (Specify) Catonsville, Maryland 21. Signature of 22. Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy., Funeral Home, P.A. S.E., Glen Burnie, 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events executed and burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24a Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No has prior to completion of cause of death? certificate 2 No 1 Yes After this certifications funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မှ 1 Tes 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1-Natural 5 Pending injury To the Hospital or Attendil within 24 hours after death. To the Funeral Director; A completed filled in by the ft · death. 2 Accident
3 Suicide Investigation M 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) 55 State Registrar

12-00512

Joshua Kenneth Clark

State of Maryland / Department of Health and Mental Hygiene

1-For State

Reg. No.

Physician/

1. Decedent's Name (First, Middle, Last)

Physician/

Month Day

Year

3. Month Day

Year

3. Month Day

Year

		1- For State Registrar	Certificate of	of Death		R	eg. No.			
Physici	an/	Decedent's Name (First, Middle,Last)			-	2. Date of Dea Month January 1		3. Time of Death 1330 hrs		
Medical Exami	ner	Joshua Kenneth Clark 4a. Facility Name (if not institution, give street and number)		8, 2012 4c. County of Dea						
		University Hospital		Baltimore	or Location of Dea		Baltimore City			
Funeral		5. Social Security Number 6. Sex 7. Age	th(MM/DD/YYYY) 9. E	Sirthplace (State or						
Director		213-33-5201 1 M 2 F 2	20 Y		ays Hours N	o5/30)/1991 Fore	eign Country) MD		
		Usual Residence of Decedent						I dod to i do Cita Limite		
w any			Oc. City, Town or Loca					10d. Inside City Limits 1 Yes 2 V No		
yland r-f sh	ģ	MD Harford 10e. Street and Number	Jarrettsv	111e 10f. Zip Code		11	Og. Citizen of What Co			
with the Maryland as 23a or 28a-f sho	Director	1608 Randallwood Court			.084	ľ	USA	only (
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f shent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent E Armed Forces?	If		Hispanic Origin? (an, Mexican, Puer	Specify Yes or No rto Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,		
ter de:		1 Yes 2 2	No 1	Yes 2 V	lo specify:		Specify:	White		
ours af itural	d by	15. Decedent's Education (Specify only highest grade comp	leted) 16a. Decede	ent's Usual Occup	pation (Give kind o		16b. Kind of Busines	s/Industry		
136 hin 72 hou e. than "na than "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+ 1.2 th) during r	most of working I	fe. DO NOT use r n/a	etired)	n/a			
5-003 led withi Hygiene.	E	17. Father's Name (First, Middle, Last)				me (First, Middle, N				
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medical	BeC	Lloyd Kenneth Clark, Jr.				ly Ann C				
Z = 5 = 5	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Str	eet and Number o	r Rural Route Num	nber, City or Town, Sta	te, Zip Code)		
		Kim Gosnell / Mother	1608 20b. Place of Dispo	Randa11	wood Ct.	, Jarret	tsville, M	D 21084		
- v - = v		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State			emetery,	Date	20c. Location - City t	or rown, state		
timora t. Pages l timent of l rant: If		4 Donation 5 Other Specify:	Atlantic		ry 1/	/24/2012	Glen Burn	ie, MD		
Baltimo permit. Page Department o Important: injury or oth		21 Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd., Nottingham, MD 21236								
Physician		28a Part I. Enter the disease, or complications that caused the						Approximate Interval		
/Medical Examiner	i	failure. List only one cause on each line. Immediate Cause (Final disease a. Contact Gunshot	Wound of Head					Between Onset and Death		
	Ш	or condition resulting in death) Due to (or as a consequence of the condition resulting in death)	uence of):							
	ě	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the conditions)	uence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury diacrimidated events resulting in death) Last Due to (or as a consequence)	uence of):					2.		
cuted nd rransit		d	,							
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED								
8760, ificate be ig physic s the bur		IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth		etal death 3	Ectopic preg	nancy	23d. Date of delive Month	ery Day Year		
Box 687 e death certifit the attending	Physician	past 12 months?	ne of death	Other (Specify)						
. BG he dea y the a	Ę,	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death b	out not regulting in the	undorlying eque	aivon in Part I	23e Did to	obacco use contribute t	o the cause of death?		
Records, P.O. Box 68. The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	2	Fat II. Outer significant conditions Continuous Continuous	at not resulting in the	underlying cause	given in raici.			obably 4 Unknown		
cords, aw require has been si 2 should b	eted			<u> </u>		24a. Was a		autopsy findings available		
OCOI te law te has ge 2 st	Completed					_ autop perfor 1 ✓ Yes	rmed? death?			
Vital Rec ysician: The l his certificate b		25. Was case referred to medical		26.Pla	ce of Death (Chec		2 10 1	703 2 110		
of Vital ig Physician: Afer this certifi neral director,	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 🗹 ER/Outpatier	nt 3 DOA	Other Nurs	sing Home 5	Residence 6 Oth	er:		
_ ੜੈੂ ਪੜ		27. Manner of Death 1 Natural 5 Pending FOUND: 28a. Date of Injury FOUND:	found:		jury at Work? Yes 2 ✔ No	28d. Describe h Subject sho	now injury occurred t self	· -		
/isior r Attend ter death virector: n by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be Jan 18, 2012 28e. Place of Injur	1220 hrs ry - At home, farm, stre					Rural Route Number, City		
Div pital o	E		le Family Home			or Town, S 1608 Randally	vood Ct, Jarrettsville	e, MD		
Division To the Hospital or Attens within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 1 Certifying Physician: To the best of my k one) 2 Medical Examiner: On the basis of examiner.								
To tl withi To tl	Medical	29b. Signature and title of certifier	1000		nse number		29d. Date signed (M			
		The Soller Ward	2080		.M.E.		January 19, 20			
	}	30. Name and address of person who completed cause of dea	ath (Item 23a)				1			
41		Victor Weedn MD JD Assistant Medical E		N. Baltimore	Street, Baltim	nore, MD 2122	23			
St	ate	31. Date filed (Month, Day Year) 32. Registrer's	Signature			· · · · · ·				

OSME

10 V

2012

IANUARY

CARDAMONE

ELIXE

Registrar DHMH 17 Rev 06-2011

State

29b. Signature aj

JONES,

CRNP

2300 DULANEY VALLEY RD.

s of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ 1 9 ay 201^{rea} 8:15 A M Richard Fradd Collins January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12618 Circle Drive Rockville Montgomery 1 Year If Under 24 Hrs If Unde Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Min. (Month, Day, Year) Hours 577-34-6517 Director 1 X M 2 □ F 83 Yrs. October 27, 1928 Washington, D.C. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 💢 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 12618 Circle Drive United States ed other than "natural", or items event, the Medical Examiner mu death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married by 2 X No hours after Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) should be filed with and Mental Hygien 7 is marked other th Manager Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 Gladys Fradd Charles C. Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelley C. Osborne / Daughter 12020 Bayswater Road, Gaithersburg, Maryland 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Montgomery Crematorium, Inc 1

Burial 2

Cremation 3

Removal from State January 22, 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2012 Signature Flutteral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, 300 West Montgomery Avenue, Rockville, Maryland 20850 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami law requires that the death certificate be executed Chronic Obstructive Pulmonary Disease and-trar resulting in death) Last Due to (or as a consequence of). physician s the buria buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) õ in the past 12 months?

1 Yes 2 No Year Month Pregnant at time of death Day 1 Yes 2 L 9 Unknown the g Unknown signed by tid be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertensive Cardiovascular Disease 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Alzheimer's Disease 24a. Was an has page performe or Attending Physician: The certificate 2 🗆 No Yes 2 X No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 X Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending ours after death.

neral Director: Af

filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hoo To the Fune completely f Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifier

scome

Jerome S. Putnam, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

D0014111

5530 Wisconsin Avenue #800, Chevy Chase, Maryland 20815

29d. Date signed (Month. Day, Year)

January 19, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For State	State of Ma	ryland / Depa	artment of I tificate of I		Mental Hy	20	112	01400
	Registrar 1. Decedent's Name (First, Middle,	Last)	061	incate or i	Jean	2. Date of De			3. Time of Death
Physician/ Medical	<u>Al</u> exander	F. Chappel				Januar	y 14, 20) 1 ^{Year}	12:04 PM
Examiner	4a. Facility Name (if not institution, g				r Location of Deat	th	4c. Count	y of Death	
	Suburban Hospit 5. Social Security Number		7	Bethe If Under 1 Year	sda I If Under 24 Hrs			gomer	
Funeral Director	169-30-0688 Usual Residence of Decedent		(In yrs. last birthday) 86 Yrs.	Months Days	Hours Min.		ay, Year)	9. Birthp Count Turk	
and show 1 at	10a. State 10b. County		10c. City, Town or Loc	ation				10	Od. Inside City Limits
Maryli 28a-f stiffied rect	Maryland Montgo	omery	Mon	tgomery	Village				1 🗌 Yes 2 🛣 No
h the bendance	10e. Street and Number			10f. Zip Code			10g. Citizen of		,
Jeath with the Maryland tems 23a or 28a-f she rer must be notified at Funeral Director	9647 Shadow Oak				0886		United		
L.5	11. Marital Status 1 □ Never Married 2 🗓 Marrie 3 □ Widowed 4 □ Divorced	d 12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 🛣 Note 11 ☐ Yes, Give Year or Dates.	0	/as Decedent of H Yes, specify Cuba ☐ Yes 2 🔀 No		pecify Yes or No- to Rican, etc.)	D10	ce - America ck, White, e Whit	tc.
2 hou "nate edica	15. Decedent' (Specify only highest	s Education grade completed)	(Give k	ent's Usual Occup ind of work done	during most of wo	rking	16b. Kind of E	Business/Ind	lustry
ithin 7 than the M	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DC	NOT use retired) Le Engin			Text	· i 1 a	
iled w Hygi other ent, t	17. Father's Name (First, Middle, Las	<u> </u>	Tenes	TC Blight		me (First, Middle,	, Maiden Surnam		
/lan d be fi Mental arked itic ev	Dimitros Chacho	poulos			Eleni	Leontis	5		
lan, shoult and b and b is ma	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street	and Number or Ru	ıral Route Numbe	er, City or Town,	State, Zip C	ode)
trid 2 tealth im 27 her tr	Lena Chappel/Wif	e			ak Drive	, Montgo	mery Vi	11age	, MD 20886
Baltimore, Maryland 21215-0036 Dermit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygelen moortant: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exami ance. To Be Completed by	20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spi	ecify)	20b. Place of Dispos cemetery, crem Gate of H Cemeter	atory or other plac leaven 'Y	20	18 1 18,	20c. Location Silver	Sprin	g, Maryland
Bal Depa Impo any ii	21. Signature of Funeral Service Lio	1	701/00 Ro	Name and Addre	ss of Facility Ro Inc. 30	bert A. O West M	Pumphre Iontgome	y Fundry Av	eral Home/ enue
	23a. Part 1. Enter the disease, or co		01498 Roo	the mode of dvin	Maryland	d 20850	rest		
Physician/	Immediate Cause (Final	y one cause on each line.			9, 00011 00 001 010	or respiratory an	1000,		Approximate Interval Between Onset and Death
Medical	disease or condition resulting in death)		gan Failu onsequence of):	re					
Examiner	Sequentially list conditions,	Aspirat	ion Pneum	onia					
je je	cause. Enter Underlying Cause (Disease or injury	Due to (or as a c						- 5	
xecuted nand al-transit Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. ————————————————————————————————————	oneoguanae of					-	
60 ate be executed hysician and the burial-transit dical Examil	resulting in death) Last	Due to for as a c	onsequence on.						
760 icate g phys is the		d							
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Medical Certificate: To Be Completed by Physician/Medical Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1							ry Day Year
P.O. s that the strattle gned by be detailed by Pl	Part II. Other significant conditions	contributing to death but	not resulting in the ur	derlying cause giv	en in Part I.	23e. Did t	obacco use cont	ribute to the	e cause of death?
ords, P.O. Be requires that the derbeen signed by the should be detached letted by Physic	Acute Renal Fai	lure				1 🗆	Yes 2 □ No	3 Prob	ably 4 🛭 Unknown
Records, The law requires arte has been sig page 2 should the	Hypoxic Respira	tory Failure				24a. Was		Were autop	sy findings available
Rec The Is ate ha						perfo	ormed?	death?	
Vital Reco ysician: The law 1 s certificate has to director, page 2 s	25. Was case referred to medical examiner?	Hospital:			ace of Death (Che				
fVi Physi this c ral dir	1 Yes 2 X No	1 X Inpatient	2 ER/Outpatient		4 ☐ Nursing F		dence 6 Oth		
ivision of or Attending P after death. Director: After t in by the funers Certificate:	1 🕱 Natural 5 🗌 Pending 2 🔲 AccidentInvestigat	(Month, Day, Y	(ear) injury	28c. Injury work M 1 🗆	rat ? Yes 2 □ No	28d. Describe I	now injury occurr	red	
Divisior tal or Attend tal or Attend al Director: A led in by the t	3 Suicide 6 Could no 4 Homicide determine		- At home, farm, stree Specify)	et, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rural F	Route Number,
Divi	(Check 2 Medical Exaconly one) 3 Certifying N	hysician: To the best of my uminer: On the basis of exar urse Practitioner: To the b	nination and/or investig	gation, in my opinio death occurred at the	n, death occurred he time, date and p	at the time, date a	and place, and du	e to the caus	se(s) and manner stated
To cor	29b. Signature and title of certifier	(Denerally	ets		OUG34U	5	29d. Date signer		ay, Year)
5	30. Name and address of person who David Guevara-N	ieto, MD 86	00 01d Geo	,	Road, Be	ethesda,	Mary1a	nd 208	314
State	31. Date filed (Month, Pay Year) JAN 2 4 2012	32. Registra s	Signature						
Registrar DHMH 17 Rev 06-2011	JAN & TLUIL	hand by.	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 16:10 PM M Durham Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore of Maryland Medical N/A1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) Country) 214-84-8222 **Director** 1 🛣 M 2 🗆 F 49 feb 7, 1962 Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 116 S. Broadway Street 21231 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 X Never Married 2 Married ☐ Yes 2 TNo Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Mitchell Ivan Durham Arlene Joyce Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is 1 any injury or or M. Paulette Wildberger, sister 5 Highshire Court Dundalk, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place Metro Crematory, Inc. 01/21/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Uncompensated conjective heart failure disease or condition resulting in death) Medical **Examiner** evere mitral sequego tation Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Mital value prolapse Hospital or Attending Physician: The law requires that the death certificate be executed unknown attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Day 2 No 1 Yes 2 9 Unknown the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular accident 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe certificate 2 No Yes 2 No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director; Afte completely filled in by the fun 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Pactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Fox 01/20/2012 Lvans resident Kes ovol 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Fox Evans Greene Street, Bultimore MD 21201 22 South 31. Date filed (Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Audrey Υ. Drayton January 21, 2012 2:56 A MMedical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4407 Woodlea Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 509-84-2862 1 🗆 M 2 🗶 F **Director** 79 AUG 2, 1932 Antigua Usual Residence of Decedent or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No N/AMD Baltimore 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? ò er than "natural", or items 23a o Funeral 4407 Woodlea Avenue 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💥 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: Specify. Completed 3 Widowed 4 X Divorced **Black** Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Social Worker School System l other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be file alth and Mental F 27 is marked of 2 Walter Davis Mia Challanger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 s of Health a If item 27 i Aurora D. Drayton, daughter 4407 Woodlea Avenue Baltimore, MD permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗌 Burial 2 🛚 Cremation 3 🗀 Removal from State Metro Crematory, Inc. 01/23/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. Signature of Funeral Service Licensee George MacNabb 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final SUPVANUC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician by Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 100 Month Day Year ed by the a detached f P.O. been signed k should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After 1 1 Natural Division s after death. Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D35102 January 23, 2012 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) North Charles Street Baltimore Mary land 3901 N10(5 W.D. 32. Regist

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Physician/ Month 2012 Medical Barbara Morris Davis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kalhin Ho Snital If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours **Director** 1 🗆 M 2 😾 F 12-12-1931 NC 80 M. Dans Usual Residence of Decede 10a. State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1X Yes 2 □ No MD n/a Baltimore 10e. Street and Number ö 10f, Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 21209 6206 Pleasant View Avenue USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. SpecifyAfrican-American 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore City Public College (1-4 or 5+) Social Worker and Mental Hygier is marked other t School Systems Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 127 is marked er traumatic e Clifton Morris Sr. Mattie Wooten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billy D. Davis/ Husband 6206 Pleasant View Avenue, Baltimore, MD 21209 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō cemetery, crematory or other place)
Metro Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1-23-2012 Baltimore, MD 4 Donation , 5 D Other (Specify) 21. Signatur o Fuhera Service Lensee 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that eadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) and Due to (or as a consequence of). resulting in death) Last attending physician that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 Ho 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? after death.

Director: After this certificate! Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No. ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Dea 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes Investigation 6 Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

"Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 22 per th g923 1-24-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First Middle | ast) 2. Date of Death Day **Physician** PM 4a. Facility Name (If not institution, give street and number) 2012 17 January /Medical 4b. City, Tewn, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 **X** M 2 □ F 155-28-1779 74 June 30,1937 Director New Jersey Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 28a-f DE Sussex Ocean View 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō 127 Naomi Drive items 23a 19970 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐XNo Specify ģ White Specify: 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than Mechanical Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Joseph A. DeAngelis Eleanor Villella ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois DeAngelis - Wife Health tem 27 i 127 Naomi Drive, Ocean View, DE 19970 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages
Department of Important: If it any injury or o once. ō 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Eglington Cemetery 01/21/2012 4 ☐ Donation \$\int 5 ☐ Other (Specify) Clarksboro, New Jersey 22. Name and Address of Facility
Harman Funeral Ser

420 West Broad St

Clen Burnic Ad. 2100
enter the mode of dyng, such as cardiac or enter the mode of dyng, such as cardiac or enter the mode of dyng, such as cardiac or 21. Signatu ral Service Licensee -Harman Grayburn Dr. Grayburn Dr. Boro, NJ 0806 V 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): 1Day Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) ician and burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical death certificate be the as 1 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year detached for Day Pregnant at time of death 5 Other (specify) 2 No P.O. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 ☐ Yes 2 ☐ No 2 X No certificate Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 X No 1 Inpatient 3 🗌 DOA 2 ER/Outpatient 6 Other (Specify) 2 After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year, or Attending 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation death. 2 Accident filled in by the Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after City or Town, State) To the Hospital within 24 hours a To the Funeral D Hospital 29a. Certifier (check only 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier 29c. License number RES-000 January 17 2012 30. Name and address of person who completed cause a death (Item 23a) (Type, Print) PANDEY ARVINO 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) -State Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:57 AM Jamuary 18, 2012 Margaret Ruth Dunkerly Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert 7150 Persimmon Lane Owings Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Davs Hours (Month, Day, Year) 215-09-6111 Director 1 M 2XX 94 02-19-1917 Virginia ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Calvert Owings 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 7150 Persimmon Lane 20736 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2X X No If Yes Give 1 ☐ Yes 2 🔀 No Specify: "natural", 3XWidowed 4 ☐ Divorced Specify: Completed Year or Dates White traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Cora Lee Kiser Henry Oaty Falls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn R. Sacker - Daughter 7150 Persimmon Lane, Owings, Maryland 20736 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, any injury or 1 X Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify) Zion Cemetery 01-23-2012 Elkridge, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd. Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes ←□ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2- No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred or Attending 1 Natural injury 5 Pending s after death. 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

68760 Box (P.O. Records, of Vital Division filled in by To the Hospital o within 24 hours af To the Funeral Di completely

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Lowenthal, MD, 110 Hospital Rd, #310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year, State

29a. Certifier

(Check

29b. Signature and title of certifier

JAN 2 4 2012

32. Registrar's Signature

3 🗆 Certifying Nurse Practifioner: To the best of my kindwiedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month, Day, Year)

201

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	se Type of						-		egible.	
		For State		State	of Maryla		artment of rtificate of		and iv	rientai Hy	_	010	01100
		Registrar 1. Decedent's Name	e (First, Middle,	Last)		Cei	tillicate of	Deam		2. Date of De	Reg. No.	U12	3. Time of Death
Physicia Medic	cal	FATRI 4a. Facility Name (if		L		DANI				Month	Day 21	Year 2012	1155 M
Examin	er	Mandrin			,		4b. City, Town, o	_	of Death			unty of Death Arun	del
Funeral		5. Social Security No		6. Sex		s. last birthday)	If Under 1 Year	If Under	r 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign
Director		212-44-93		1 🗆 M 2 🗷 F	68	Yrs.	Months Days	Hours	Min.	(Month, Da		Ida	-
ind show at	٦	Usual Residence of 10a. State	10b. County		10c.	City, Town or Lo	cation			Jogot (3,1313		10d. Inside City Limits
Maryla 18a-f tified	rect	MD	Anne A	Arundel	L	othian							1 Yes 2 XNo
vith the N 23a or 2 st be no	Funeral Director	10e. Street and Nun 182 W. E		nt Road	•	-	10f. Zip Code 2071	1			10g. Citizen USA	of What Cou	ntry?
items items		11. Marital Status		12. Was Dec	edent Ever in		Was Decedent of H					Race - Americ	
ırs after c ıral", or I Examin	ed by	1 ☐ Never Marri 3 ☐ Widowed			2 ፟█ No ve		If Yes, specify Cub 1 ☐ Yes 2 🔀 No			rican, etc.)		Black, White, cify Whit e	
72 hou " nat ı edica	Completed	(Spe	15. Decedent cify only highes	s's Education of grade completed	t)	(Give	dent's Usual Occup kind of work done	during mos	st of worki	ng	16b. Kind o	of Business/In	dustry
iene.	Con	Elementary/Seco	ondary (0-12)	College (1-4 or 5+)		0 NOT use retired, ect Manac	·			Develo	opment	Company
illed wall Hyg	Be	17. Father's Name (F		•					ner's Name	e (First, Middle,			1
ld be l Menta arked	안	Edward L	. Danie	els				Sara	a Get	ty			
1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Na J. A. Tur			nd		ng Address (Street W. Bay Fi						Code)
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 Burial 2 4 Donation	X Cremation	3 Removal from	n State		natory or other pla	,		Date		on - City or To	
permit. P Departm Importar any injur		21. Signature of Full		- 11	F1)	22	rney Cren . Name and Addre	ess of Facili	itv			oine, 1	
2		Levery	I Hier	little M	01251		Going Hon Beverly I	ne Cre	emati ckrot	on Serv te, P.A	vice P. A. Clai	O. Bo ksvil	x 784 le, MD 2102
Physician/		23a. Part 1. Enter 1 shock, or hear Immediate Cause (I disease or condition	t failure. List on Final	complications that ly one cause on e	caused the de ach line.	eath. Do not ente		ng, such as	s cardiac o	r respiratory an	rest,		Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	-	a. Due to	(or as a conse		10						/// <i>U/V J</i> +)
Lxammer	er	Sequentially list con		b. — Dun to	/24.22.2.2.2.2.2								
ted I Insit	Examiner	cause. Enter Under Cause (Disease or i	(Disease or injury tiated events c										
be executed sician and burial-transit		that initiated events resulting in death) L											
te be hysicia	dical			d									
ertifica ding pl	/Me	IF FEMALE:		22c If yes ou	tcome of preg	nanov							
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. with Part Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	months?	1 Live	Birth 2 🗌 Fo gnant at time o	etal death 3	Ectopic pregnan Other (specify)	су				Date of deliv Month	ery Day Year
at the ed by t detach		Part II. Other signifi	icant condition	s contributing to	eath but not r	esulting in the u	nderlying cause gi	iven in Part	: I.	23e. Did to	bacco use c	ontribute to t	ne cause of death?
quires then signer	ted by									1 🗆 🕆	Yes 2 N	o 3 🗆 Pro	bably 4 🗆 Unknown
law re nas be e 2 sh	Completed									24a. Was a	sy	prior to co	psy findings available impletion of cause of
The icate h		05.111						_,		perfo 1 🗌 Yes	rmed2 2 No	death?	2 🗆 No
sician certif lirecto	To Be	25. Was case referre examiner? 1 ☐ Yes 2	d to medical √No	Hospital:		7 FD(0 :	Oth	lace of Dea				MAND	RINGINA
g Phy er this neral c		27. Manner of Death	1 _	28a. Date		ER/Outpatier 28b. Time of injury	28c. Injur	ry at		me 5 Resid			CART CTI
eath. or: Aff	fica	1 Natural 2 Accident 3 Suicide	5 ☐ Pending Investiga 6 ☐ Could no	ation	nn, Day, rear	Injury	M 1 🗆	Yes 2	No				
al or Att s after d il Direct ed in by	Certificate:	4 ☐ Homicide	determin	28e. Place	e of Injury - At ing, etc. <i>(Sp</i> ec		eet, factory, office		2	28f. Location (S City or Tow		mber or Rura	Route Number,
Hospit 24 hour Funera stely fill	Medical	(Check 2		Physician: To the laminer: On the ba	sis of examinat	ion and/or invest	igation, in my opini	on, death o	ccurred at	the time, date a	nd place, and	due to the ca	use(s) and manner stated
o the	ž	only one) 3 29b. Signature and t	☐ Certifying N	Nurse Practitione	r: To the best o	f my knowledge,	death occurred at	the time, da	ate and plac	ce, and due to t	he cause(s) ar	nd manner as and	stated.
->-0		MAN	i dran	173	Jen	Agun	D		138		-		
)./		30. Name and addre	ess of person wi	ho completed cau	se of death (Ite	em 23a) (Type, P	(rint) DEFE		H	1. A	VAIA	Disc	MD2140)
Stat	e	31. Date filed (Month	1 29049	32. F	Registar's Sig	rocked	ソビビ	1175	1,0	74 / 11	ANALL	ULI)	1111/1/1901
Registra		JAN 2 4	1 2012	Lever,	1. 1	न्युक्त कर्ण च ाहा							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #758 Per FH G923 1/26/2012 Ih State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Eva Mae Davis Physician/ JaMnth 18 5:55am._M 20年2 Medical 4a. Facility Name (if not institution, give street and number) o. City, Town, or Location of Death Baltimore Examiner 4c. County of Death Futurecare/Sandtown Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Sept. 17, 1915 South' Carolina 1 □ M 2 🏝 F 220-24-6786 Hours **Director** 96 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Baltimore Y Yes 2 ☐ No 10f. Zip Code 21215 10e. Street and Number 10g. Citizen of What Country? Funeral 3509 Grantley Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 ₩ Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. Do NOT use retired)
Domestic Cook 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 4th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Regina Mental Haskel Sewell pe t t. Page 1 and 2 should be tment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print)
Robert Davis/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 3509 Grantley Rd. Baltimore, Mary Land 21215 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Draftary, Relage other place) tery permit. Page 1
Department of
Important: If it
any injury or o 1 XI Burial 2 Cremation 3 Removal from State 1-26-12 Pikesville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Road Baltimore,MD.21215 Signature of Juneral Service Licensee 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Athenselente Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N certificate 1 🗌 Yes 2 HNO 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Yea 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Physician/ HEL Medical Facility Name (if not institution, give street and number, 4b. City Town, or Location of Death of Death **Examiner** Stown Kandall tospice Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Min 212-30-4566 **Director** 1 - M 2 -28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified 1 Yes 2 No more 17 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral ellow 21209 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iter I Examiner ı Armed Forces Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: "natural" 3 Nidowed 4 ☐ Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT, use retired) (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) tician Heathcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည tabsha 99 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Konold immonds Aue attimore_ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State altimore National 30/2012 4 Donation 5 Other (Specify) o Funeral Service I 22. Name and Address of Facility Howell wher reights Aue ardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on 2 Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Examine Due to for as a densiquence of: the attending physician and ched for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death Director After this certificate has been signed by the adding by the funeral director, page 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 □ Probably 4 □ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Tes Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certifica 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Othe 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred Natural Accident Describent 5 Pending 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

Registrar

and address of

31. Date filed (Month, Day,

cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:00M 10, hoose 2012 Idhl Januar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1322 Ingleside Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours Min (Month, Day, Year) 212-44-6017 1 □ M 2 🗶 F **Director** 67 Yrs 03 SC 31 or 28a-f show notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No MD NA 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 1322 Ingleside Ave 21207 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2X Married by Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) Mercy Hospital Nurse Aid Jth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hester M. Pringle Wallace Stater Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health : Andrew Duboase Jr. Husband 1322 Ingleside Ave, Baltimore, Md 21207 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) King Memoiral Park 1/27/12 Woodlawn, Md 22. Name and Address of Facility March F/H West |4300 Wabash Av Signature of Edneral Service Licer timore, Md 23a. Part 1. Enter the disease, or comple ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Ons d Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ntar Physician/ disease or condition resulting in death) minue Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Director: After this certificate has autopsy performed?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined hours after City or Town, State) thin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 10

State Regis<u>trar</u>

		Please	Type or Prin								0	
	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 2 0 1 2									0 0 1 1 1 0		
		Registrar 1. Decedent's Name (First, Middle, Last)		Cert	uncau	e or De	alli	2. Date of De	Reg. N	10. 2	3. Time of Death
Physiciar Medic		Deborah Mildred	Donohue						Month Janua:		ear 22,2012	8:15A M
Examine		4a. Facility Name (if not institution, give s 2417 Dixie Lane	street and number)					cation of Deat	h	4	c. County of De	
Funeral		5. Social Security Number 6. Se.		(In yrs. I	ast birthday)	If Under	1 Year If	Hill Under 24 Hrs			g. B	ford irthplace (State or Foreign
Director			□ M 2 🗗 F	52	Yrs.	Months	Days F	Hours Min.	March .	26,1	959 Ma	ountry) ryland
and show	'n	Usual Residence of Decedent 10a, State 10b. County		10c. Cit	y, Town or Loc	ation			1			10d. Inside City Limits
Maryl 28a-f otifiec	irect	Md. Harfo	ord		Fores	t Hi	1					1 🗆 Yes 2 🔀 No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 2417 Dixie Lane				10f. Zip	210)50		10g. (Ditizen of What C	Country?
or iten	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ▼ N If Yes, Give		If	Yes, spec	ify Cuban, N	Mexican, Puer	pecify Yes or No- to Rican, etc.)	-	14. Race - Am Black, Wh	ite, etc.
urs aft tural", al Exa	ted	3 Widowed 4 Divorced	Year or Dates.				X No S			_	Specify:	White
an "na Medic	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	\		ent's Usua ind of wor NOT use	k done durir	n ng most of wo	rking	16b.	Kind of Busines	s/Industry
ygiene ygiene her tha	ωŀ	Elementary/Secondary (0-12)	College (1-4 or 5-	-)	Medica	1 Tec	hno1c	gist		He	alth Ca	re
d be filed Mental H arked ot atic ever	P P	17. Father's Name (First, Middle, Last) Richard J. Roh					18		me (First, Middle ey Blos		n Surname)	
2 shoul h and l 7 is m trauma		19a. Informant's Name/Relationship (Typ			1				ıral Route Numbe			
f Healt item 2 other	H	James Donohue 20a. Method of Disposition		use	Place of Dispos	Dix:	e of	ne Fo	rest Hi		Location - City of	
Page ment o ant: If ury or		1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	1	emetery, crema Lghview	-		1-2	5-2012	 Fal	lston,	Md.
permit. Departi Import any inji		21. Signature of Funeral Serve License	е									me of BelAir
Physician/ Medical		2.a. Part 1. Enter the disease, or implier shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	TA	STA				or respiratory a		in	Approximate Interval Between Onset and Death
Examiner			Due to (or as a	consequ	uence of):							
sit of	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						1				
executec an and rial-trans	Exal	Cause (Disease or injury that initiated events resulting in death) Last										
te be e	dical	C.										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	<u> </u>	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/fths? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23d. Date of Month							23d. Date of d Month	elivery Day Year		
that the	y Ph	Part II. Other significant conditions con	ntributing to death bu	t not res	ulting in the un	derlying o	ause given i	in Part I.	23e. Did t	tobacco	use contribute t	to the cause of death?
en sign	ted b								1 🗆	Yes 2	2 No 3 🗆	Probably 4 🗆 Unknown
sician: The law res certificate has be lirector, page 2 sho	Completed								24a. Was auto perfo 1 Yes		prior to death?	utopsy findings available completion of cause of es 2 \(\sum \) No
sician: certific irector	<u> </u>	25. Was case referred to medical examiner? 1 Yes 2	ospital:				Other	of Death (Che				
ding Phy: h. After this funeral d	ate: lo	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day,		ER/Outpatient 28b. Time of injury	28	sc. Injury at work?		dome 5 Hesi 28d. Describe			cify)
al or Atternater dear I Director:	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)				M 1 Yes 2 No at, factory, office 28f. Location (Stree City or Town, \$				eet and Number or Rural Route Number, State)		
e Hospita 124 hours Funeral letely fille	g	29a. Certifier 1 Certifying Physic (Check 2 Medical Examin only one) 3 Certifying Nurse	er: On the basis of exa	amination	n and/or investig	gation, in r	ny opinion, d	death occurred	at the time, date	and plac	e, and due to the	cause(s) and manner stated
To the vithin comp	Σ	29b. Signature and title of certifier	. ractitorier, to the	ocat Of H	iy kilowledge, C		License nui		piace, and ude to		ate signed (Mon	
r l) -)	PHYSEC	IAV			2005	847	5	JA	MARY	23 2012

State Registrar DHMH 17 Rev 06-2011 PHECEP MINATPUNIN SIO UPPAR CHIESAPHAKTE, BRUATA, NO 21614

31. Date filed (Month, Day Year) 4 2012

32 degister

JAN 2 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Shirley Diane Dawson 01 2012 8:00p. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Genesis Multi-Medical Center Towson Social Security Numbe 8. Date of Birth
(Month, Day, Year, If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days 1 M 2X Min. Hours 214-64-0163 Country) 58 Director Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** MD Baltimore 1 Yes 2 X No Towson 10e. Street and Number 10g. Citizen of What Country? 7700 York Road 21204 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 12th grade College (1-4 or 5+) Clerk Constant Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ray Bridges Mary E. Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1605 Woodbourne Ave, Baltimore, Md 21236 Mary E. Dawson-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State **Baltimore** permit. Page 1 a
Department of IImportant: If ite
any injury or ot Magnetay prematory or other place) 2 United Ind. Memorial Park 1/24/2012 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Woodlawn, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Pteysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical I P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Dav Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Brain Injury 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 Matural Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical within 24 hound to the second the second to 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Exertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 0

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 2012

31. Date filed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20^{Day} 2012 10:27 John Richard Duffin Jan Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Pines Talbot GENESIS HealthCare -Easton Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Hours (Month, Day, Year) 10/21/1936 Pennsylvania Director 179-26-5425 75 Usual Residence of Decedent , or items 23a or 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore 1 🛛 Yes 2 🗌 No Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 222 Purlington Road 21093 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give John Duffin Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Specify: Year or Dates White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mental injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event the Mental Injury or o College (1-4 or 5+) 12 Broker Transport Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas В. Duffin Mary Regina Brophy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Harrington / Daughter <u>Purlington Road, Lutherville, MD 21093</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 101/23/2012 Hanover, Maryland 22. Name and Address of Facility 21. Signature of Juneral Service Anatomy Gifts Registry 7522 Connel<u>ley Dr.</u>, Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each light. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any standard in Cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mipleed filled in by the furneral director, page 2 should be detached for use as the burial-transit scular resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Certificate: To 1 \sum Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Tyes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Name and address of person who completed cause of ceath (Item 23a) (Type, Print) DUTCHMANS

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 William H. DePue 7:15 P^{M} Tanuary Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Chevy Chase Chevy Chase Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 26, **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 🕅 M 2 🗆 F 1920 Washington, 579-16-9240 Director Yrs 91 D.C. Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 20815 8700 Jones Mill Road United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Specify. Year or Dates. 1943-1946 White It of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Trave1 Clerk Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Edward DePue Marion Frances Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Hill / Step-Daughter 6407 Heathcliff Lane, Tracys Landing, Maryland 20779 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once. Date Montgomery Crematorium, Inc. January 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bethesda, Maryland 2012 21. Signature our Unerpat Service Iccensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Arrthymia Sequentially list conditions, Examine Durate for es e consequence of If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events burial-transi Congestive Heart Failure and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 __ Live Birth 2 __ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🗌 No 1 L Yes

Be

မ

Medical

iner?

27. Manner of Death

X Natural

4 Homicide

29a. Certifier

Accident

1 X Yes 2 □ No

6 🗌

25. Was case referred to medical 26. Place of Death (Check only one)

Hospital Other: 4 🛮 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at injury 5 Pending work? 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number,

01

28d. Describe how injury occurred

Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

D35579

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8218 Wisconsin Avenue #305, Bethesda, Maryland 20814 Susan J. Miller, M.D.

State Registrar

31. Date filed (Month, Day, Year) **JAN 2** 4 2012

32. Registrar's Signature

the Hospital or Attending thin 24 hours after death.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 21, 2012 Barbara Marie DiGiacomo 11:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Baltimore Timonium If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1/24/1932 029-22-9941 Massachusetts **Director** 1 M 2 XF 79 Yrs. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Lutherville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 2121 Pine Valley Drive 21093 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Baltimore Co. Schools Cafeteria Aid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. 2 Albert Bates Bella Sylvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gabriel R. DiGiacomo / Husband <u> 2121 Pine Valley Drive Lutherville, MD 21093</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation Dulaney Valley Mem. 1/26/2012 Timonium, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature eral ervic Towson, Maryland 21204 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Due to for as a ponsey uenou offi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 2 **X** No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 Kunknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? perform 2 🗆 No Yes 2 X No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practitioner: To the basis of examination and/or investigation, or also considered at the time, date and place, and the cause(s) and manner stated. 29a. Certifier (Check X Certifying Nurse Practitioner to the best of my monitory, or the 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 06-2011

State

Registrar

JAN 2 4 2012

				Plea	i se Type o r a d item 8 State o	Print in	Black I	ndelible l	nk. Ens	sure A	All Copie	s Ar	e Legik	le.		
			1 - State Registrar		Otate (Certificate of Death						Reg. No 2012 01415				
Г	Physicia Medic		Decedent's Name	e (First, Middle	, Last) Jo	S				2. Date of D Month	Date of Death Month Day Year 21.00 A M					
and the same	Examir		4a. Facility Name (if)	11	e at the	e	4b. City, Town	or Location			4c. County of Death Wicsmico					
-	Funeral Director	Г	5. Social Security Nu 226-62-66	ımber	6. Sex 1 X M 2 F		. last birthday) Yrs.	If Under 1 Ye Months Da	ar If Unde	er 24 Hrs. Min.	8. Date of 2 (Month 2 1 2 0	0 1/1/94/	Birthplace (State or Foreign			
	nd how at	٦	Usual Residence of 10a. State	Decedent 10b. County		10c. (City, Town or Lo	ocation						10	Od. Inside	City Limits
	Maryla 28a-f s otified	Director	MD			Willa	ırds						es Z No			
	ith the 3a or t be n		10e. Street and Num 7327 Canal					10f. Zip Cod		7.4		10g. C	Citizen of What		try?	
	eath w	Funeral	11. Marital Status	Street		edent Ever in l	J.S. 13.	Was Decedent of	2187		ecify Yes or No	-	14. Race -	JSA America	an Indian	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Me. Acal Examiner must be notified at ance.	Completed by F	1 ☐ Never Marrie		ied Armed Fo 1 X Yes If Yes, Giv Year or D	_2 □ N aArn /e	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						Black, White, etc. Specify: White			
15-(72 hou n "natu le vica	nplet	(Spec		it's Education st grade completed)	(Give	dent's Usual Occ	e during mo	st of worki	ing	16b.	Kind of Busin	ess Ind	lustry	
212	within giene.		Elementary/Seco 12	nday (0-12)	College (1	-4 or 5+)	ille. L	DO NOT use retire Bo	dy Shop				Aut	omot	ive	
and	be filed ental Hyg ked oth ic event	To Be	17. Father's Name (F	irst, Middle, L	•	P11!			18. Mot	her's Nam	e (First, Middle					
ary Sign	should be and Ment is marked raumatic e		19a. Informant's Nar	me/Relationsh	Charles R.	EIIIS	19h Maili	ing Address (Stre	et and Numb	oer or Rurs			ladden	a Zin C	ade)	
Σ̈́	nd 2 st ealth a m 27 is ner trau		Joseph R. El		ner			E. Maple A					, rown, old	o, 210 o	ouc)	
nore	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Dispo	Cremation	3 Removal from	State 20b.	cemetery, cre-	osition (Name of matory or other p	· ·		Date (2012	20c.	Location - Ci	-		
altin	mit. Pa bartme sortan / injury		4 Donation 21. Signature of Fun					ke Cremato 2. Name and Ado			/2012		Belts	ville,	MD	
<u>~</u>	permi Depar Impo any ir		Dorota Ma	rshall 🤇	Doube	Ollan	Acol M	aryland Cr	emation	Service	es, PO BO	X 14	13 Baltii	nore,	MD 2	1203
			23a. Part 1. Enter th shock, or heart Immediate Cause (F	tailure. List o	complications that nly one cause on ea	ch line.							,		Approximation Interval Be Onset and	etween
	Medical		disease or condition resulting in death)		a. MALL Due to	(or as a conse	<u> </u>	PLASM	WITH	UNI	KNOWN	PR	MARY	0.11	Onset une	- Doun
	Examiner	Į.	Sequentially list con	ditions,	b. ———											
	ited 1 unsit	Examiner	if any, leading to init cause. Enter Underl Cause (Disease or ii	njury	Due to	Or as a conse	quence oi):									
	e executed ian and urial-transi		that initiated events resulting in death) La		C. Due to	(or as a conse	quence of):							\top	-	
760	cate be physic s the bi	edic			d					-						
Box 68760	The law requires that the death certificate be at the has been signed by the attending physicis page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 — Yes 2 —	onths?		Birth 2 Fe nant at time o	tal death 3	Ectopic pregna					23d. Date of		ry Day	Year
P.O.	requires that the de been signed by the should be detached	, Phy	9 Unknown Part II. Other signific	cant conditio			esulting in the u	underlving cause	given in Par	H.	23a Did i	hobacco	use contribu	te to the	- cause of	death?
S, F	uires th n signe ald be o	ed by									1 🗆			_	_	Unknown
Records,	aw req	Completed									24a. Was				sy findings	
Re	sician: The law r certificate has b lirector, page 2 sl		OF Was seen with	J &							pert 1 ☐ Yes	ormed?	dea	th?	2 17No	
/ita	Physician: 1 r this certifica ral director, p	To Be	25. Was case referred examiner? 1 Yes 2		Hospital:	Innationt 2	ER/Outpatier		Place of Deather:				9		11.01	0.08.
of	ng Phy fter thi		27. Manner of Death	5 🗆 Pendin	28a. Date		28b. Time of injury	28c. In			me 5 Resi 28d. Describe			pecity)	4021	190
Sion	ttendi death. ctor: A: / the fu	Certificate:	Natural Accident Suicide	Investig	ation ot be	of lainer. At h			Yes 2	-	2004					
Division of Vital	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,		4 Homicide	determi	buildi	ng, etc. (Speci	fy)				28f. Location (City or To	vn, Stati	e) 			nber,
)	e Hosp 24 ho e Fune eleted fi	Medical	(Check //2 L	_J∕Medical E:	Physician: To the bastaminer: On the bast Nurse Practioner:	is of examinati	on and/or inves	tigation, in my op	nion, death o	ccurred at	the time, date :	and plac	e, and due to	the caus	se(s) and m	nanner stated.
	To the within comp	only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)														
			30. Name and addres	ss of person w	ho completed caus	e of death (Ite	m 23a) (Type, F	Print)	.03	04	(0)		1/ /2) [[<u></u>	
+	\		6 HUAL 31. Date filed (Month)	y W.	My	1.0 Mg	bee	1733	Solo	13V	rupy	0	us	21	180	~
	Stat Registra		JAN 2	4 2012	Cenery	egistrar's sign	gare				/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Martha Lee Fendler January 5:20 A^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Days Hours Min. $JuIv^{Month, Day, 1}$ Maryland 74 Director 216-32-4289 Usual Residence of Decedent 28a-f show 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 1 🗆 Yes 🌉 No Maryland Harford Havre de Grace 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 106 Bayland Drive Unit 17 21078 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💢 No Black, White, etc. Completed by 1 \square Never Married 2 \square Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 ☐ Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Self Employed is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Benjamin Clayten Leah Felser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. James M. Fendler, Jr.,Son 638 Parkwyrth Avenue Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/21/12 Baltimore, Maryland 21. Signature of Funeral Service License Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. nterval Between Onset and Death Immediate Cause (Final Physician/ 27 disease or condition y revs Medical resulting in death) Due to (or as a or nsequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or ii that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g 🗌 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Nes 2 No 3 □ Probably 4 □ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 N After this certificate 1 Yes the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Plywithin 24 hours after death.

To the Funeral Director: After it completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ar d title of certifier 29d. Date signed (Month, Day, Year) 2012 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAMES N. Charles ST CON 6701

Registrar

32. Registrar's Sanature

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Frazier Edward sames 10,00A M JUNUARO 7105 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 317 Harlem Lane Catonsville If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) **Director** 212-48-7459 1 🛛 M 2 🗆 F 63 Yrs Nov 10, 1948 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. Count 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Marvland Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 317 Harlem Lane 21228 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Electrician Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked 2 Madge O. Sheetz Raymond Lindsay Frazier should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is
any injury or other trau 317 Harlem Lane Catonsville, Maryland 21228 Josephine Frazier, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/20/12 Baltimore, Maryland 21. Signature of Funeral Service Li ense Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, 299 Frederick Road Baltimore, Inc. Marvland 21228 Momas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Kidney concer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No the 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🗖 No Hospital Other: 1 Tes ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated NS Ry April M.D 29b. Signature and title of certifier 00057465 5703 Baltimore MD 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-5. Regionpallse M.D 2835 Smidn AV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ORdham Mont g Medical 4a. Facility Name (if not institution, give street and nur Examiner ounty of Death tarwood 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Hours Min. 62 Yrs. 5445 Director 1 M 2 D F "natural", or items 23a or 28a-f show 10b. County Town or Location 10d, Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21172 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify If Yes Give 3 Divorced Completed Mac Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retiged) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Prin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Fundral Services 8728 Vaudhn Koga Srupe 23a. Part 1. En er the disease, o complications that caused the death. Do not enter the mode of dying, such as cardia shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition resulting in death) nroplesm Myear Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? After this certificate 2 No Yes the Hospital or Attending Physician: filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) MANDRIN Other: 1 Yes 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Division 2 No Accident Investigation Director: Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 052756 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012ª CORINNA CRAWFORD FINNEY January 21 11:25P ^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death COLLEGE MANOR NURSING HOME Lutherville Baltimore County Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Mar 26. 1 🗆 M 2 🛛 F Days Hours 216-52-8826 86 T925 MARYLAND Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗆 Yes 2 🔀 No Maryland Baltimore County Lutherville 10e. Street and Number 0 10g. Citizen of What Country? 10f. Zip Code Funeral 23a 300 West Seminary Avenue 21093 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter Black, White, etc. þ 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Chauncey Crawford Jane Hancock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 and 2 s Health s em 27 i John M.T. Finney IV P.O. Box 569, Monkton, Maryland 21111 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Mount Crematory 1/24/2012 Baltimore, Maryland Signatur of Fundal Sérvice Dice see MTTCHELL WIEDEFELD FUNERAL HOME, IN 6500 York Road, Baltimore, Maryland Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each diffe. Approximate Interval Between et and Death Immediate Cause (Final Physician/ me disease or condition Medical resulting in death) Due to for as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day the 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. ρ signed by be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? SSISTER Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Spec 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred -AC. Li Natural 5 Pending Division 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature apd title of certifie address of person who completed payse of death (Item 23a) (Type, Print) 16701 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink / Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death $3:10pm_M$ Physician/ Month Jan Day 20 Year 2 Patricia Joy Fleetwood Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Jpper Chesapeake Hospital Belair Harford Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 25 earl 954North Carolina Months Days Hours 214-74-8080 57 **Director** 1 □ M 2**X** F Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director Maryland Belair 1 Yes X No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1871 Edgewater Drive Apt.C 21040 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black White, etc. Black "natural", or by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medicine Technician VaughnBoarding Home 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Vaughan Arthur Fleetwood 19a. Informant's Name/Relationship (Type, Print)

Tamara Marie Fleetwood/Dau 1871 Edgewater Dr. Apt. C. Belair, Md. 21040 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Greenimounit Cemetery 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) 1/27/2012 21. Signature ral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 ReisterstownRoad Baltimore, MD.21215 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Stage Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Drail to (or as a consequence of) cause. Enter Underlying Exami Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗀 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hou

To the Fune

completely fi (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 060768 29b. Signature and title of certifier Upper Chesipate Dr. BelAIV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

		For State Registrar	State of Maryland	/ Depa	artment of Health	and Mental Hy	_	12 0142		
Physic		Decedent's Name (First, Middle, La Arthur	st) DeLano		Frost	2. Date of De Month	ath Day Y	3. Time of Death		
Med Exami		4a Facility Name (if not institution, give	e street and number)		4b. City, Town, or Location	of Death	4c. County of	Death		
Funera Directo		Usual Residence of Decedent	7. Age (In yrs. last 48	Yrs.	If Under 1 Year If Under Months Days Hours	Min. (Month, Da		P. Birthplace (State or Foreign Country) MD		
Maryland 28a-f sho etified at	Director	MD 10b. County		10d. Inside City Limits 1 Yes 2 □ N						
with the 23a or 2		10e. Street and Number 3341 Avondale	Ave		10f. Zip Code 21215		10g. Citizen of What			
1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	- 1	Was Decedent of Hispanic Or f Yes, specify Cuban, Mexican I ☐ Yes 2 ▼ No Specify		14. Race - Black, Specify:	14. Race - American Indian, Black, White, etc. Specify: Black		
within 72 hours after giene. er than "natural", o ; the Medical Exam	Completed by	15. Decedent's (Specify only highest g	Education rade completed) College (1-4 or 5+)	(Give kind of work done during most of work				16b. Kind of Business/Industry		
2 should be filed within the and Mental Hygiene. 27 is marked other tha traumatic event, the N	To Be C	12th grade 17. Father's Name (First, Middle, Last) Arthur Hayward	Maiden Surname)	preneur						
and 2 should Health and Mi em 27 is mar ither traumati		19a. Informant's Name/Relationship (Damion Frost-S		19b. Mailii 511 8	ng Address (Street and Numb Darien Roa	er or Rural Route Numbe id, Baltin	er, City or Town, Stat	e, Zip Code) 2120 6		
		20a. Method of Disposition 1 X Burial 2 Cremation 3 C 4 Donation 5 Other (Spec	Removal from State cem	netery, crer	esition (Name of natory or other place)	Date 1/21/12	20c. Location - Ci			
permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licer		122	Name and Address of Facility of West OO Wabash A	t t				
Medica Examine		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it is a list of the cause of the	one cause on each line. ESRD So Due to (or as a consequen	n H			rrest,	Approximate Interval Between Onset and Death		
e death certificate be executed the attending physician and thed for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a consequent d	y leath 3	Ectopic pregnancy Other (specify)		23d. Date Month			
uires that the n signed by the		Part II. Other significant conditions	ditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of 1 Yes 2 No 3 Probably 4							
The law require: ate has been sid page 2 should I	Completed by	<u></u>				24a. Was auto perfe 1 Yes	psy prid prmed? dea	re autopsy findings available or to completion of cause of ath? Yes 2 No		
sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:	2/0	Other:	ath (Check only one)		2 1		
Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. Funeral Director: After this certificate has been signed by the attending phystely filled in by the funeral director, page 2 should be detached for use as the	Certificate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatic 3 Suicide 6 Could not 4 Homicide determined	28a. Date of injury (Month, Day, Year)	M 1 ☐ Yes 2 ☐ No At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route						
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical ((Check 2 Medical Exam	ysician: To the best of my knowled niner: On the basis of examination ar rse Practitioner: To the best of my	nd/or inves	tigation, in my opinion, death o	ccurred at the time, date	and place, and due to	the cause(s) and manner sta		
To the within To the comp		29b. Signature and title of certifier	H.D.		29c. License number	36	29d. Date signed (/			
			IUTANI M.D.	82	Print) N RUTAY	V ST B	alti mon	e, MD		
St Regist	ate	31. Date filed Month Day, Year 2012	32. Registrar's Signature	6-11	,					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Barbara Ann Gagliano Physician/ 8:05PM JANUARY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE SAINT JOSEPH MEDICAL OWSON MENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 215-30-9221 Hours 77 Director 1 □ M 2 🛣 F June 18,1934 Maryland 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Baltimore 1 🗌 Yes 2 іXNo 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 8620 Kelso Drive Apt.A212 21221 United States items "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Specify: Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. C&P Telephone Elementary/Secondary (0-12) College (1-4 or 5+) Accounting Clerk Companý 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental F 7 is marked of Gilbert Henry McQuay Margaret Emily Seymore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Dobry- Daughter 3054 Oak Forest Drive, Baltimore, MD 21234 1 and 2 s of Health item 27 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth January 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 26, 2012 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service License SAFUNETUL Chapel & Cremation Service Harford Rd. Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cause (Final diserse or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying THE LIVER Cause (Disease or injury that initiated events resulting in death) Last attending physician at for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year 9 Unknown P.O. Pa<u>rt II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.</u> 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has perform death? 2 🗌 No Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1601 OSLER DRIVE m.D.

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

PLACEMENTASE Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 2012 01423 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sean Patrick **Gallagher** 2012 A MJanuary 7:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 24 Cedarwood Road Baltimore Catonsville Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Director 215-50-3652 1**X** M 2 □ F Yrs FEB 9, 56 1955 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho Director 1 Yes 2 X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 24 Cedarwood Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14 Bace - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) General Contractor Home Improvement is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ M. Gallagher Simkevicius John Dorothy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilarie A. Gallagher, wife 24 Cedarwood Road Catonsville, MD Important: If item 2 any injury or other tonce. other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ÷ 1 🗌 Burial 2 🛛 Cremation 3 🗆 Removal from State Metro Crematory, Inc. 01/24/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Myocardial Infarction Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 N 2 🗌 No **Division of Vital** or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital o within 24 hours aff To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D57916 January 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franz S. Sewchand, M.D. 700 Geipe Rd., Suite 200 Catonsville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 6 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2012 Year Oniel Joseph Garcia 22 2:15 P M Jan. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Mamasion Assisted Living Nottingham Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Nov • 26 Birthplace (State or Foreign Country)
 LA **Funeral** Age (In yrs. last birthday) Hours Days 1<u>907</u> **Director** 104 214-01-4241 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Baltimore Timonium MD 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 21093 USA 313 E. Timonium Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white "natural" Completed 3 ₩ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Standard Oil Transportation Dispatcher 10 other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked o any injury or other traumatic even မ Frances Dudeck James Garcia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9601 Dunkeld Ct., Nottingham, MD 21236 Constance Garriques/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 1/25/12 Dulaney Valley Memorial Gardens Timonium, MD Donation 5 Other (Specify) 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd. Timonium, MD 21093 Clary Inc. Bryan 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lij d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Due to (or as a c Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a conse nce of Exami Cause (Disease or impury that initiated events attending physician and for use as the burial-tran Due to (or as a conse resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed cate 1 Yes 2 No Yes 2 No Be 25. Was case referred to dedical 26. Place of Death (Check only one) n 24 hours after deau... he Funeral Director: After this ce noleted filled in by the funeral dire Hospital Other: မ 1 Ye 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) r of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 No Accident Investigation M 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death sceured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examiner: To the basis of examiner: To the basis of examiner: To the basis of examiner: pration and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated fmy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause death (Item 23a) (Type, Print)

State Registrar Jose Hernandez, M.D.

Suite 509, Towson, MD

7505 Osler Dr

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 7:454 Allen 20,20% James Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Country) 500 24 394 **Director** 1 M 2 □ F 8 Usual Residence of Deced 28a-f show 10b. County 10d. Inside City Limits must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No Hagerst Washington ō 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 1185 91749 items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant, If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exal Completed 3 🗌 Widowed 4 🗌 Divorced white Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Corpsman 19 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Walter prolton 21740 19a. Informant's Name/Relationship (Type, Print) ural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or ocolton 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important; If it any injury or o 🗌 Burial 2 🔀Cremation 3 🗌 Removal from State Dermott 4 ■ Donation 5 ☐ Other (Specify) Vegas, NY 21. Signature of um ral ervice License 22. Name and Address of Facility Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Approximate or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final disease or condition Intersh Physician Medical resulting in death) Due to (or as a consequence of): **Examiner** 6 Gequentially rist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and thed for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year been signed by the a should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Difeese 1 Yes 2 No 3 Probably 4 Unknown den i 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed' 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No Yes 2 filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death . Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) ٥ 10061117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 MANCISCO 31. Date filed (Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:50 A M Mildred Louise Hughes 2012 Tunuan Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign h 26 1 🗆 M 2 🗓 F Days March March Director ^{≅7}1927] 212-24-8674 Mary land 84 Usual Residence of Decedent or 28a-f show 10b. County with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 123 W.29th Street 21218 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 X Never Married 2 Married à Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Private Industry Domestic Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important; If item 27 is marked of Page 1 and 2 should be Joseph M. Hughes Catherine Barrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Jefferson Sr./Nephew 2400 Liberty Road Eldersburg, MD 21784 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place. injury or 4 ☐ Donation 5 ☐ Other (Specify) 1-24-2012 Lansdowne MD 21. Signature of Funeral Service in hisee 22. Name and Address of Facility Chatman-Harris Funeral Home any 5240 Reisterstown Road Baltimore, MD 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Carcinoma Non-Small . Medical resulting in death) Examiner Sequentially list conditions if any keading to immediate Examiner Due to for as a cynsection coord cause. Enter Underlying g physician and as the burial-transit b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director. After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy the past 12 months? signed by the atte Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 D 9 Unknown 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 \(\square\) No Be 26. Place of Death (Check only one) Hospita Other: ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier AT 2438946 01,15,2012

Registrar

State

Parkway, Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

East University

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2012 **Physician** 16 5:45a.M Holt Annie Ruth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Home Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director 212-28-3728 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exercitors into the contribution. Director 1 Yes 2 No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 2525 Calverton Heights Ave 21216 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black \$ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2yrs 1 and 2 should be filed within Health and Mental Hygiene, tem 27 is marked other than Elementary/Secondary (0-12) Licensed Practical Nurse Private Duty 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Carter Leah Simmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 19a. Informant's Name/Relationship (Type. Print) Bettye Holt Haskins-Daughter 2525 Calverton Heights Ave, Baltimore, permit. Pages 1 and Department of Healt Important: If item 2: any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1/23/2012 Arbutus Memorial Arbutus, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Marchand Address of Facility ala 21215 4300 Wabash ave, Baltimore, Md as 23 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the short in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementia **Physician** Ema disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transi Due to (or as a consequence of): attending physician for use as the buria 68760 Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy signed by the atte Day Month Year 5 ☐ Other (specify) P.0. 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ₩0 24a. Was an cate has page 2 s autopsy this certificate 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes death. 2 No 2 Accident Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 Homicide e Funeral 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of cortifie

Juyant

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mes

1505

32. Registra:

Himan

Day

Browe

as for

29c. License number 2527

lowson,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Betty Jean Herron 8:15 PM 2012 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPI tal ok Bultimore Baltimore If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours 216-30-9084 78 **Director** 1 □ M 2 🛣 F 03/21/1933 TNUsual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 ☐ Yes 2X No Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number er than "natural", or items 23a or the Medical Examiner must be Funeral 21122 U.S.A. 4 Brookview Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Deceud... Armed Forces? ⁴ ☐ Yes 2**X** No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates. White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker should be filed with and Mental Hygien 7 is marked other ti 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ၉ Harris Emmitt Bratcher Georgia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, MD Mrs. Lynda Milam / Daughter 4 Brookview Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State MD Veterans Cemetery 01/23/2012 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lic 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD MO1479 Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and Due to (or as a consequence of): resulting in death) Last physician Medical that the death certificate be Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth 2 Live Birth 4 Pregnant at time of death in the past 12 months? Month Day Year signed by the a 1 ☐ Yes 2 ■ g ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 decubitus, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? pesitomitis 24a Was an has page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: To the Hospital or Attending 5 Pending Natural 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Patel no January 17, 2012 Wilesh W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NILESH PATEL MD SIN HOSPITAL OF BALTIMORE NILESH SINA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

12-00540 Faith Lynn Hott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

aitii Lyiiii i lott		1- For State Certif	ficate of Death	Reg. No.	2012 0142			
Physicia	in/	Registrar 1. Decedent's Name (First, Middle,Last)	Date of Death Month Day	Year 1259 hrs				
Medical Exami	ner	Faith Lynn Hot 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	January 19, 2012	ounty of Death			
		Johns Hopkins Bayview	Baltimore					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	Feb25,201	9. Birthplace (State or Foreign Country) MD				
any .	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location		10d. Inside City Limits			
. .	5	MD Baltimore D	undalk		1 Yes 2 X No			
th the Maryland 23a or 28a-f sho notified at once.	Dire	10e. Street and Number 1956 Haselmere Road	10f. Zip Code 21222	USA	10g. Citizen of What Country? USA			
5-0036 led within 72 hours after death with the Maryland stygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Fune	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year	13. Was Decedent of Hispanic Origin? (Spirit Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
ours afi atural' caming	b b	or Dates:	Sa. Decedent's Usual Occupation (Give kind of videring most of working life. DO NOT use reti		of Business/Industry			
21215-0036 uld be filed within 72 be Mental Hygiene. marked other than "nu c event, the Medical Ex	Completed	College (1-4 or 5+)	n/a	n	/a			
115-00 e filed win al Hygien red other	Be Co	17. Father's Name (First, Middle, Last) Patrick Hott		e (First, Middle, Maiden Sur Ida L. Shac				
D 2121: should be fi and Mental J 7 is marked		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or F	Rural Route Number, City o	or Town, State, Zip Code)			
≥ da 2 margh da Z	ŀ	Patrick Hott /father	6901 Fait Ave.		MD 21224 ation - City or Town, State			
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and I Important: If iten 27 is n injury or other traumatic		1 Burial 2 Cremation 3 Removal from State Back 4 Donation 5 Other Specify:	Virewhtiematory 1/	24/12 Ba	ltimore MD			
Baltimo permit. Page Department o Important: injury or oth		21. Signature of Funeral Service Licensee	22. Name and Address of Facility 3 Connelly Fune		e. Balto. MD			
Physician	_	23a. Hart I. Enter the disease or omplications that caused the death. Do failure. List only one cause on each line.	not enter the mode of dying, such as cardiac of	or respiratory arrest, shock,	or heart Approximate Interval Between Onset and			
Medical Examiner			ned Death in Infancy(SUDI)	Death			
1	5	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
	Examina	cause. Enter Underlying Cause (Discers or Injuly It at Inflicted c.						
uted nd ransit		events resulting in death) Last Due to (or as a consequence or): d.						
60, ate be execute hysician and te burial - tran	Medical	x UNPENDED ☐ AMENDED 23a, 27, 28	a-f,per me,g925 3-15-1	l2 sm				
ox 687 ath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 Fetal death 3 Ectopic pregna		late of delivery onth Day Year			
O. Be at the de d by the stached f		Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause given in Part I.		contribute to the cause of death?			
s, P.(nires that n signed d be det	ed by				o 3 Probably 4 Unknown			
Division of Vital Records, P.O. rai or Attending Physician: The law requires that its after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	Completed			24a. Was an autopsy performed? 1 Yes 2 No	 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 			
tal Recian: The certificate ector, page	Be C	25. Was case referred to medical examiner? Hospital: 4 lengticet 2 4 55	26.Place of Death (Check					
n of Vital I ding Physician: After this certifi funeral director,	٩	1 V Yes 2 No I I I I I I I I I I I I I I I I I I	R/Outpatient 3 DOA Oute4 Nursin Bb. Time of Injury 28c. Injury at Work?	ng Home 5 Residence 28d. Describe how injury				
OD C ending ath. or: Af	tion	Natural 5 Pending (Month, Day, Year) Fd 1-19-12	Ed 11:50 am 1 Yes 21X No	Unknown				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident 3 Suicide 4 Homicide Accident Investigation Suicide Accident Suicide Accident Investigation Suicide Accident Accident Suicide Accident Suicide Accident Suicide Accident Accident Suicide Accident Suicide Accident						
n 24 hc		29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/	death occurred at the time, date and place, and	d due to the cause(s) and m	nanner as stated.			
To th withi. To th	Medical	2 Medical Examiner. Of the basis of examination and and manner stated. 29b. Signature and title of certifier	29c. License number		e signed (Month, Day, Year)			
		en us.	O.C.M.E.	Janua	ry 20, 2012			
/		30. Name and address of person who completed cause of death (Item 23 Ling Li, MD Assistant Medical Examiner 900 W		1223				
	ate	31. Date filed (Month, Day, Year) 32. Registra's Signature	protect A Temporary	1223				
Regist		1.4.4.4.0040	1. barle					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month D. Norval Haugh 11:45 Medical January 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Good Samaritan Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 | F Hours 1272071921 Maryland **Director** 215<u>-</u>14-1523 90 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland <u>Baltimore</u> Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Southerly Road # 1408 21286 U.S.A. death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Completed Specify: 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pharmaceutical Representive Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Arthur Haugh Nannie Delaplane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Haugh / Wife 800 Southerly Road #1408 Towson, Maryland 21286 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Hilltop Service Corp 1/24/2012 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0 disease or condition C 0 Medical resulting in death) Due to (or as a consequence of) Examiner Arra if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami tran and Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Day 9 Unknown Unknown by the signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page performe certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes nours after death.

neral Director; Affilled in by the fur 2 Accident 2 🗌 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1anuary 20,2012 H 59540 30. Name and address of person who completed cause of death (Item 23a) (Type P OTI 0

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Laura Month O 1 Holland-Onley 2012 6:45p.M 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harmony Hall Assisted Hall Columbia Howard 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Min. 219-22-1182 Hours Director 1 □ M 2 🔏 F 96 12 05 15 MD Usual Residence of Decedent show or 28a-f show notified at 10c. City, Town or Location 10d Inside City Limits Director MD Howard 1 🗌 Yes 2 🔀 No Columbia 10e. Street and Number 'n 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 10973 Millbank Row 21044 U.S.A. death Was Deceu Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: Black 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working l Hygiene. other than ' Bureau Engraving life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade <u>Printing Assistant</u> Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Albert John Holland other traumatic Anna Madora Smoothers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Michael Marshall-Son 10973 Millbank Row, Columbia, Md 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth once. 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place New Cathedral 4 ☐ Donation 5 ☐ Other (Specify) 1/23/12 Baltimore, Md Signature of Fureral Service Licens 22. Name and Address of Facility
March F/H West
4300 Wabash Av Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred the Funeral Director; After Natural 5 Pending death. 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 🗆 Certifying Nur 🖢 Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) IN D47447 1/19/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Lazris 6334 Cedar Lane, Columbia, Md 21044 32. Registrar State **Registrar**

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Item 1 per dr.,g923,01/24/2012dhb
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Gray Holly **Delores** 2. Date of Death 3. Time of Death Physician/ Month OYCS 6:43 PM 2012 January Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Match Point Drive <u>Arnold</u> 7. Age (In yrs. last birthday, Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Hours Months Min. 09/28/1943 Washington, DC Director 579-54-2344 Yrs 68 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🛚 Yes 2 🗌 No <u>Anne Arundel</u> Arnold MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21012 761 Match Point Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 X Divorced Black traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Housing Manager Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Minnie Evans John Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Match Point Drive, Arnold, MD 21012 Kathy Watson / Daughter 761 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) :01/16/2012 | Hanover, Maryland Anatomy Gifts Registry Anatomy Gifts Registry 21. Signature Funeral Service Licenses 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ stace disease or condition resulting in death) Medical Due to (or as a con wuence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE signed by the attending be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 4 Unknown should t Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Ves 2 No certificate has page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔀 No ျင 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) fter this 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🛛 Natural 5 Pending injury death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of

State Registrar Son

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

R143194

Dr. #G Linthicem, MD 21090

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Pamela Helen Insley 20, 1:42 A January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Baltimore Gilchrist Center 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Days 1 □ M 2 🗓 F Min. 63 Baltimore, Maryland 215-54-0711 Director January 15,1949 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director Middle River 1 ☐ Yes 2 🖁 No Baltimore Maryland ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 23a Funeral 21220 7132 Cunning Circle items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give 2 🔀 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White "natural", 3 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Glauber's Candy Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Irene Smith Allen Barnes Douglas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7132 Cunning Circle Middle River, Maryland 21220 19a. Informant's Name/Relationship (Type, Print) Harold Insley (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel All 20a. Method of Disposition 20c. Location - City or Town, State January 21, 2012 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility
Evans Funeral Chapel & Cremetion Services—Parkville
8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (s a consequence of **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): Exami attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medica that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy perform To the Hospital or Attending Physician; The I within 24 hours after death.

To the Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) \bowtie O 1 🗌 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature and title of 29d. Date signed (Month, Day, Year) P Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Jamuary 2012 Richard 18 Ianuly 4:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Hours 045-32-1799 Director 68 1 X M 2 🗆 F Connecticut Usual Residence of Decedent Feb. 23 1943 show 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Baltimore Phoenix 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral Constantine 21131 U.S.A. items (Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or iten edical Examiner þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify. White Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Advertising Marketing Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, # once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Stephen Charles Ianuly Stella Costa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Almarie Ianuly / Wife 26 Constantine Drive, phoenix, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State DulaneyValleyMem.Gdns 1/21/2012 4 Donation 5 Other (Specify) Timonium, Maryland 21. Signature of Fun and Fermi ense 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition UNG VOAR Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Dan to for as a consequence of If any leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has performed certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: ဂ္ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 28d. Describe how injury occurred Natural 5 Pending injury work? 2 🗆 No Accider
Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide Medical Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

6

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2,30 PM 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jones amle Tanuar) Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Luch Kaven Community Living Center Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** M 2 □ F Hours **Director** or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 212-08 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in 11. Marital Status Forces? β 1 Never Married 2 Married Yes Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates. 1946 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnan and Mental Fishered of ည Page 1 and 2 should be ment of Health and Ments nown 19a. Informant's Name/Relationship (Type, Print City or To 19b. Mailing Address (Street and Numb) Department of Health ar Important: If item 27 is any injury or other trau Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town gemetery, crematory or other Burial 2 ☐ Cremation 3 ☐ Removal from State 31-2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enge the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death VOVASCUL -Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ungestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) physician a s the buriaf-t Physician/Medical Box 68760 attending pt for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 2 No Unknown 9 Unknown P.0 signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 2 should Were autopsy findings available prior to completion of cause of death? has autopsy performed After this certificate har funeral director, page 2 No 1 🗌 Yes 2 Yes 25. Was case referred edical Division of Vital Be 26. Place of Death (Check only one) 2 No Hospital 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 2 🗌 No 2 Accident
3 Suicide 1 🔲 Yes after death. Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type 3900 0 ch KS eovae and

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	-	For State Registrar	Plea	se Type o State			d / Depa		t of H	lealth		All Copie Mental Hy		ne 20) 2	0	1436
Physiciar Medica		1. Decedent's Name	e (First, Middle	Last) F		_	1	NSD				2. Date of De	eath	Day	Year 2012		ime of Death
Examine	_	4a. Facility Name (if		give street and n	,	nter			Town, or	Location	of Death		- 1	4c. County	,	_	
Funeral Director		5. Social Security Ni	umber	6. Sex 1 ☐ M 2 F	7. Ag		ast birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	ay, Yea		Cou	ntry)	State or Foreign
and show at	or	Usual Residence of 10a. State		.,			y, Town or Loc	cation				Dec. 1	17,	1948	Wası		ide City Limits
e Maryla r 28a-f s notified	Direct	MD 10e. Street and Nun		e George	's	Sea	t Plea	sant	Codo				10	0.22	1A / 1 O		Yes 2 No
h with the ns 23a o	Funeral Director	6615 Dry		eet					743					Citizen of JSA	What Got	, arter y 7	
fter of , or i	۾	11. Marital Status1 ☐ Never Marri3 ☐ Widowed			Forces? s 2 X Give		II	Yes, spec	ify Cuba	spanic Ori n, Mexical Specify	n, Puerto	cify Yes or No- Rican, etc.)		Bla	ce - Ameri ck, White Afri	, etc.	American
72 hours an "natur Medical E	Completed		15. Deceder cify only highe	t's Education st grade complete		5.1)	16a. Deced (Give F		rk done a	ation Juring mos	st of worki	ng	16b	. Kind of E			11.02100
d withir Tygiene ther thaint, the	မ Be Co	17. Father's Name (2	(1-4 or 5)+)	Manage					e (First, Middle,		ligio			
d be file Mental H arked o	١٩	Albert H		asi)								e (First, Midale, ne Cous:		en Surnam	ne)		
2 shoul th and I 27 is m traums		19a. Informant's Na Gem Norr					1	-				Route Numbe				Code)	
of Heal	ı	20a. Method of Disp	osition	3 Removal fro	om State	20b. P	lace of Disposemetery, crem	sition (Nan	ne of			Date	_	. Location		Town, Sta	ate
nit. Page artment ortant: injury o		4 ☐ Donation 21. Signature of Fur	5 Other (S	pecify)	/	Fina	al Jour							odbir			704
Depar Depar Impol any ir		Deve	In L	Helte	2 MO			Goin Beve	g Ho rly	me Ci L. He	remat eckro	tion Ser	rvi .A.	ce ^P Clar	ksvi	Box lle,	784 MD21029
Physician/ Medical Examiner		23a. Part 1. Enter ti shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List o Final	nly one cause on	each line	the death		BR			cardiac c	r respiratory ar	rrest,			Interv	eximate all Between t and Death
_ =	Examiner	Sequentially list confrant, leading to improve cause. Enter Under Cause (Disease or that initiated events	mediate rlying injury	b. Due t	o (or as a	a consequ	ience of):										
sate be executed physician and the burial-transit	<u> </u>	resulting in death) I		d	o (or as a	a consequ	ience of):										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?		/e Birth egnant a	of pregnal 2 Feta t time of d	Ideath 3 ∟	Ectopic p Other (sp		у					ate of deli	very Day	Year
uires that the name of the signed by all the deta	δ	Part II. Other signif	icant conditio	ns contributing to	death b	ut not resi	ulting in the u	nderlying	cause giv	en in Part	I.	23e. Did t					se of death?
The law req	Completed											24a. Was auto perfo 1 \(\subseteq Yes	psy ormed	?		ompletic	dings available on of cause of
ysician: s certific director	To Be	25. Was case referre examiner? 1 ☐ Yes 2 ☐		Hospital:	Inpatie	ent 2 🗆	ER/Outpatien	t 3 🗆 D	Otho	er:		only one) me 5 \square Resi	dence	MAN			NATECTIZ
ling Phy 7. After thi funeral		27. Manner of Death	5 Pendin	28a. Da (Me	te of inju	ry	28b. Time of injury	2	8c. Injury work	at ?		28d. Describe				<i>y</i>	7170
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Certificate	2 Accident 3 Suicide 4 Homicide	Investig 6 Could r determi	not be 28e. Pla		ıry - At ho :. <i>(Specify₎</i>	me, farm, stre	et, factory		Yes 2		28f. Location (City or Tov			per or Rura	al Route	Number,
e Hospit 124 hour e Funera letely fills	Medical	(Check 2	Medical E	Physician: To the kaminer: On the b	asis of e	xamination	and/or invest	igation, in i	my opinic	n, death o	ccurred at	the time, date a	and pla	ace, and du	ie to the c	ause(s) a	nd manner stated.
To the within to comp	2	29b. Signature and		175	36,0	wt	zi un		. License					Date signe			32012
201		30 Name and addre	ess of person v	vho completed ca	use of d	eath (Item	23a) (Type, P	rint) D		NSE	4	wy A	Na	/APE	045	MI	21401
State Registra	,	31. Date filed (Month		A 32.	Registra	r's Signat						1 6-					

Hospital or Attending Physician; The law requires that the death certificate be executed the burial-tran and Division of Vital Records, P.O. Box 68760 as use signed by pe certificate has

Physician/

Medical

Director

Funeral

Completed by

Be

၉

Examiner

Funerai

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

27 is marked other than "natural traumatic event, the Medical

Department of Health a Important: If item 27 is any injury or other trau once.

Physician/

Medical Examiner

and Mental Hygiene.

and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Be Completed by ၀ Certificate:

Examine

filled in by Medical

To the Hospital within 24 hours a To the Funeral D

	ar Accident	1 🗌 Yes 2 🗌 No 3 🗎 Probably 4 💢 Unknown						
Diabetes M.	ellítus II	24a. Was an autopsy performed? 1 □ Yes 2 🕅 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 📉 No						
25. Was case referred to medical	26. Place of Death (Check of	inly one)						
examiner? 1 Yes 2 No								
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Year) injury work? n	3d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		3f. Location (Street and Number or Rural Route Number, City or Town, State)						
	ysician: To the best of my knowledge, death occured at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred at the							

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

07009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Regional Hospita

Road 7300 Van Dusen

Laurel JAN 2 4

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Catherine Johnson A M9:45 January Medical 4a. Facility Name (if not institution, give street and number) 4h City Town, or Location of Death 4c. County of Death **Examiner** 2532 Marbourne Avenue Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours (Month, Day, Year, 220-40-9795 Months **Director** 1 M 2 Ty F 04-12-1944 Marvland 67 Usual Residence of Deceden 28a-f show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1xxYes 2 ☐ No MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2532 Marbourne Avenue 21230 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed White permit. Page 1 and 2 should be filed within 72 hour Department of health and Mental Hyglene. Important if item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Administrative Assistant</u> Marketing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Schultz Keith Mary Cecelia O'Donnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Johnson, Sr. <u> 2532 Marbourne Avenue, Baltimore, MD 21230</u> -spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1xXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 01-20-2012 Ellicott City, MD Mary's Cem. 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Licer Inc, 7250 Wash. Blvd., Elkridge, MD 21075 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final BRAINS Cancer (NONSMALL CELL) Physician/ Lung disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2005 BRAIL Metastasis Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the Unknown by signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 1 Yes Yes 2 Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of ë 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer (Month, Day, Year) 1 Natural 5 Pending Certificat 1 Yes 2 No Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year)

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

724

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signatur

William

31. Date filed (Month, Day,

JAN 2 4 2012

D31256

Maiden Choice Lave Suite 204 Baltimore

JANUARY 19,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SO. aneT 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Season's Hospice Randallstown Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ☐ F Days Months Hours Min ^{(M}177/23/1949 Sountainia Virginia 403-68-5901 62 Director ms 23a or 28a-f show must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 160 Owings Gate Road #104 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. 9 þ 1 Never Married 2 Married 2**X** No 1 Yes If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify "natural", Completed 3 Widowed 4 Divorced Black Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Real Estate Appraiser Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental firem 27 is marked of marked ည James Shelton Inez Murdock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Shelton / Sister PO BOX 11482, Berkeley, CA 94712 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1
Department of Important: If it any injury or o 4 Donation 5 Other (Specify) Chesapeake Crematory 1/21/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ -UNG Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 No Month Day Year Pregnant at time of death be detached g Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 C this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at After t Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and titl no

State Registrar

DHMH 17 Rev 06-2011

31. Date filed

ddress of person who completed cause of death (Item 23a) (Ty

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ January P₃y 2012 8:42 A M Eric Larimore Jackson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1X M 2 □ F Days (MO472711930 Washington DC 61 Yrs. **Director** Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Completed by Funeral Director Yes 2 No Bowie MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 20716 16010 Excalibur Road Apt. 3160 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1X Never Married 2 ☐ Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Local Government Auditor 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ဂ Marion Dublin Wilbur Jackson, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Hickory Bluff, Johnson City, TN 37601 Wilbur Jackson / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1/21/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death COLON CANCER Immediate Cause (Final METASTATIF Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 🗌 No 2 L Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 - Natural iniury 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b, Signature an D006485 MEDICAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONCOLORY ANNAPOUT ONCOLOGIS MEDICAL 31. Date filed (Month, Day, 32. Registrar's Şignature

DHMH 17 Rev 7/2009

State Registrar

12	-00)54	18
Cł	nris	to	oh
	ad	:	P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ristopher Sco	ott K	1- For State	ate of Maryland		artment of rtificate of			Menta	al Hy		Reg. No.	20	12	2 0 4 4
Physic		1. Decedent's Name (First, Middle							2	. Date of De	ath	Year		3. Time of Death
edical Exam	ıner	Christopher 3	Scott Kell n, give street and number)	ey	14	b. City, To	wn, or Lo	ocation of		Month 2 January		. County of	Death	*095 0*hrs
		University Hospital	,			Baltimo						, , ,		
Funeral		'		e (In yrs. I	last birthday)	If Under Months	1 Year Days	If Under 2	24Hrs. Min.			1	Foreign	nplace (State or
Director		575-53-8055	1 M 2 F		21 _{Yrs.}	Morning	Luys	Hours	141171.	August	08,	1990	Cou	ntry) Hawaii
Any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locati	on							Т	10d. Inside City Limits
	៦	Maryland Harfor	rd	Sta	æt									1 Yes 2 No
Maryla r 28a-f	Director	10e. Street and Number				10f. Zip C					_	zen of Wha	t Coun	ry?
death with the Maryland or items 23a or 28a-f shownst be notified at once.	a D	3602 Hollands Bran	12. Was Decedent	Ever in II	S 13 Wa	2115		nic Origin	2 / Spe	cify Yes or N	U.S		Americ	an Indian, Black,
leath w	uneral	1 X Never Married 2 Ma	rried Armed Forces?			s, specify					-	White,		ari irigiari, biack,
after call, on	by F		orced If Yes, Give Year or Dates:			Yes 2X	-					Specify: W		
hours "natur	ted	 Decedent's Education (Specific Elementary/Secondary (0-12) 	ify only highest grade com College (1-4 or 5		16a. Decedent during mo	s Usual O	ccupation ng life. D	n (Give kin OO NOT us	nd of wo se retire	rk done d)	16b. F	(ind of Bus	iness/In	dustry
336 thin 72 re.	Completed	12	Donogo (1-4 or c	,.,	Sales -	Genera	l La	oor			V	arious		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Helantal Angental Hygiene Americal other than "matural", or items 23a, or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	S	17. Father's Name (First, Middle,								irst, Middle,		Surname)		
2121 Ild be f Mental marke event,	o Be	Scott William Kell 19a. Informant's Name/Relationsh			19b, Mailing	Address				Bragunie		ty or Town	State	Zin Code)
AD 2 shot the and 3 27 is matic	-	Scott William Kell								ræt, M		-		_p 0130/
s l and f Heali If item		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from Sta		Place of Disposi crematory or oth ans Funera					Date ary 27,	20c. I	Location - 0	City or T	own, State
Baltimore, permit. Pages 1 an Department of Hea Important: If ite		4 Donation 5 Other So	ecify:	Crea	mation Sen	vices	 Be. 	L Air	20	12				Maryland
Ball permit Depart Impor		21. Signature of Funeral Service of	icensee Jeffrey R.	Testa (MO1	erman 22, 13 543) 3 m	ms Fu	erar Driv	fersilitye Ver Fin	1 & (remetic	n Se Arvl	rvices	- B	el Air
Physician		23a. Part I. Enter the disease, or o	complications that caused	the death	. Do not enter th	e mode of	dying, su	ich as card	diac or r	espiratory ar	rest, sho	ck, or hear	t	Approximate Interval Between Onset and
Medical/ Examiner		failure. If t only one cause of immediate Cause (Final disease	_{a.} Hanging	_		_								Death
		or condition resulting in death)	Due to (or as a conse	quence o	of):									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence o	of):									
e	Examine	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence o	rf):									
Division of Vital Records, P.O. Box 68760, To the Boptial or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	alE		d. X AMENDED 2,	3 ner	r me a92	3 1-2	7-1	2 1/2						
50, te be ex ysician burial	ledical	UNPENDED IF FEMALE:				5 1-2	.,-1,	Z VL			1 220	L Data of d	olivos	
cath certificate be attending physic for use as the bu	an/Me	23b. Was decedent pregnant in the past 12 months?	I LIVE DILLI		2 Fet	al death	3 [Ectopic p	regnand	у	230	I. Date of d Month	Da	ay Year
Box 6876(c death certificate the attending phy ed for use as the b	Ü	1 Yes 2 No 9 Unk	4 Pregnant at	time of de	eath 5 Oth	er (Specif)	<i></i>							
that the d	y Physi	Part II. Other significant condition	ons contributing to death	but not re	esulting in the u	nderlying ca	ause give	en in Part	I.	1		_		ne cause of death?
Division of Vital Records, P.O. tale or Attending Physician: The law requires that the set detail. After this certificate has been signed by led in by the funeral director, page 2 should be detach	ed by								_					bly 4 Unknown
aw req	Completed									24a. Was		pri		opsy findings available impletion of cause of
Rec The l ficate l	Сол									1 Yes	2 N		✓ Yes	2 No
/ital /sician uis certi director	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2	ER/Outpatient			Death (CI			Reside	nce 6	Other:	
Of \ ng Phy After th nneral	⊢-	27. Manner of Death	28a. Date of Inju	y ear)	28b. Time of In	jury 28	c. Injury	at Work?	20	Bd Describe	how inju	ry occurred	1	
Sion Attendi death. ctor: ,	atio	1 Natural 5 Pendi 2 Accident Invest	igation Jan 14, 2012		FOUND: 2330 hrs			s 2 ✓ N	°					
Divis	Certification:	deterr	not be		ome, farm, stree	t, factory, o	ffice buil	ding, etc.		Bf. Location (or Town, 1 30 Rocksp	State)			al Route Number, City
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach		4 Homicide 29a. Certifier 1 Certifying Ph	- 1/1		ge, death occurr	ed at the ti	ne, date	and place					-	·····
To the within To the comple	Medical	one) 2 Medical Exam	niner: On the basis of exam and manner stated.	nination a	nd/or investigati				rred at t	he time, date				
1	Σ	29b. Signature and title of certifier					icense r D.C.M.					Date signed uary 22,		h, Day, Year)
COME		30. Name and address of person v	who completed cause of de	eath (Item	1 23a)	`		· - ·			Jan			
-OMC			Deputy Chief Medic			W. Baltii	nore S	Street, B	Baltimo	ore, MD 2	1223			
S Regis	tate	31. Date filed (Month, Day, Year)	32 Registrar	's Signatu	. har	20	·							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Kenney 19 2012 January 1:53 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Days Hours **Director** 1 X M 2 D F 128-24-0132 80Yrs Dec 12, 1931 New York permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Carroll New Windsor 10e. Street and Number 10g. Citizen of What Country? Funeral USA 14712 New Windsor Road 21776 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces Black, White, etc. Completed by 1 X Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced If Yes, Give Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Electrical Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Herbert Kenney Alice Main 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shara Lora, Cousin 15717 Clifton Blvd. Lakewood. OH 44107 20a. Method of Disposition
1 □ Burial 2X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory Inc. 01/20/12 Baltimore, Maryland 21. Signature of Funeral Service Licenses Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 homa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Septic Shock disease or condition Medical resulting in death) Examiner Acute Respiratory Failure Sequentially list conditions, f on cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consiguence of use as the burial-transit Aspiration Pneumonia Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Deep Vein Thrombosis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter in the past 12 months? Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute Renal Failure Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an hin 24 hours after death.

the Funeral Director: After this certificate has Impletely filled in by the funeral director, page 2: performed? Yes 2 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner' Hospital: Other: 1 🗌 Yes 2 X No 은 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending (Month, Day, Year) work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 19, 2012 D41162 6 gm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 Doctor's Drive Germantown, Maryland 20874 Vinu Ganti 31. Date filed (Month, Day, Year) State

Registrar

JAN 2 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death NANCY Physician/ KOLODIE 2 Day 12 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 404 Catherine Avenue Linthicum Heights Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 214-76-3323 Director 1 - M 2 F 50 April 28, 1961 Maryland 28a-f shov Examiner must be notified at 10c. City. Town or Location Director Marvland Anne Arundel Linthicum Heights 1 Tyes 2X No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? 238 Funeral 404 21090 Catherine United States Avenue items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force or. Completed by 1 Never Married 2 X Married Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates 2 **X**No 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: White "natural", 3 Divorced Specify event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Warren Colbert Patricia Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 404 Catherine Ave., Linthicum Heights, MD 21090 Michael A. Kolodiej/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Metro Crematory Inc. | 01/24/2012 |Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service LicenseeAlyson K 22. Name and Address of Facility Cremation Society of Maryland Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Metastat Physician/ OLON CANCER disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner cause. Enter Underlying
Cause (Disease or injury Due to for as a nonsequence of The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) as the burialphysiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 9 Unknown þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed has page 2 Yes 2 or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: P 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No After t Certificate: 28d. Describe how injury occurred Natural injury 5 Pending after death. Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital on within 24 hours aff To the Funeral Discompletely filled in Medical 1 🗑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D 14774 MD 1-24-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HNY ANNA POLIS AZIZ 4.0 445 DEFENSE SHAHID Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

1 0010

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thelma Angela Koerber January 23 2012 4:08 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10506 Kinloch Road Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) July 23, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours **Director** 578-12-1950 1 🗆 M 2 🗶 F 1920 Washington, DC 91 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10506 Kinloch Road 20903 USA death Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. 0. Black White etc. 1 Never Married 2 Married þ 1 Yes Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify Specify: White Completed 3 XWidowed 4 ☐ Divorced Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygien Personal Assistant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Department of Health and Ment. If item 27 is marken any injury or out. Henry Nicol Fannie Hock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antonette Koerber/daughter 21711 Bigwoods Road Dickerson, MD 20842 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 01/24/12 Woodbine, MD 21. Signatur of Funeral Service Li Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Recurring Pulmonary Bronchiectasis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Division of Vital Records, P.O. Box 68760 as. IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 2 X No 1 Yes 2 9 Unknown the Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 X No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of has autopsy page performed? certificate 1 Yes 2 No 1 ☐ Yes 2√2 No Be (Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 X No Other: ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Medical Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practition er: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of de 29c. License number 29d. Date signed (Month, Day, Year) D43436 January 23, 2012 who completed cause of death (Item 23a) (Type, Print) M.D. 10801 Lockwood Dr. Suite 280 Silver spring, MD 20901 Hushna R. Baksh, filed (Month, Day, Ye 32. Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 8 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lois Epstein Kuck 20, 2012 6:05 P M January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chester River Manor Nursing & Rehab. Chestertown Kent Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
May 2, 1947 9. Birthplace (State or Foreign **Funeral** New York Washington,D.C. Days 219-46-6727 **Director** 64 1 □ M 2 🗶 F 28a-f show 10a. State the Maryland notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Kent Chestertown 1 Yes 2 No 10e. Street and Number 9 10f. Zip Code ms 23a or 10g, Citizen of What Country? Funeral 10790 Kasota Road 21620 USA items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten 11. Marital Status 14 Race - American Indian. Black, White, etc. ģ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White er than "natur , the Medical I 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Artist event, th Art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever မှ Seymour Epstein Libby Appel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George A. Kuck/husband Health a 10790 Kasota Rd. Chestertown, MD 21620 Department of Healt Important: If item 2 any injury or other i other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Final Journey Crematory 01/24/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 321 Name and Address of Facility tion Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Metastatic Breast Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transif Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be P.O. Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy jo Month Year 5 Other (specify) Day Pregnant at time of death detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an has page 2 prior to completion of cause of death? certificate performe 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 Residence 6 Other (Specify, Jospha. 4 hours after death. ... Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation
6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a Medical 29a. Certifier King Certifying Physician: To the jest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only c Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signy and title of 29c. License number 29d. Date signed (Month, Day, Year) D60301 January 23, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael E. Peimer, M.D. 122 Speer Rd. Suite 5 Chestertown, MD 21620 10 V

State Registrar Date filed (Month Toxy X

32. Registrar's Strature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 30, per DVR, g923 1-24-12 sm
State of Maryland / Department of Health and Mental Hygiene
amend #19a Per FH G924 2/29/2012 JH
Certificate of Death
Reg. No. 2012 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ A M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death mon 8. Date of Birth (Month, Day, If Under 24 Hrs. Hours Min. **Funeral** Birthplace (State or Foreign Country) Months Director 1 🗆 M 2 💢 F Yrs. KOREA 28a-f show 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 ☐ No ō 10f. Zip Code 10g. Citizen of What Country? items 23a USA Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Yes 2 If Yes, Give Black, White, etc. "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I h and Mental Hygiene. **7 is marked other than "r** Elementary/Secondary (0-12) 6 Be 17. Father's Name (First, Middle, Last) ၉ 19a. Informant's Name/Relationship (Type, Print) 50/1
Yungwoon 19b. Mailing Address (Street and Number or permit. Page 1 and 2 sh Department of Health a Important: If item 27 is KUNGWOO 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine death certificate be executed attending physician and I for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No detached for Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown Unknown P.O. To the Hospital or Attending Physician: The law requires that the þ g to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, page 2 should 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy perform After this certificate Yes Division of Vital Be 25. Was case referred to predical funeral director 26. Place of Death (Check only one) examiner? Hospita 2 No ျ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 -4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 Yes 2 No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12107 Heritage Park Circle Silver Spring, MD, 20906 Ghousia Sultana 32. Registras Signas re State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rudolph Joseph Kaplan Jr. January 9:07 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air Social Security Number 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Or 25 1929 1 🔀 M 2 🗌 Months Days Hours Min. **Director** 219-22-0529 82 Usual Residence of Decedent sa or 28a-f show be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Funeral Director 1 🗌 Yes 2 ื No <u>Maryland</u> Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a must 2303 Alex Court 21050 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 XNo Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates. th and Mental Hygiene.
77 is marked other than "natul traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steelworker Steel Production Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hannah K. Pilachowski Rudolph Joseph Kaplan Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Doris L. Kaplan / Wife 2303 Alex Court, Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🛭 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-23-12 Hilltop Service Corp. Towson, Maryland Signature of Funeral Service Licen McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ (and dema disease or condition resulting in death) MKNWM Medical Due to (or as a consequence of): Examiner MKNOW Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ prostate cancer Completed 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 aplan, Rudolph performed? Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 2 No ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Prwithin 24 hours after death.

To the Funeral Director; After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suic Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Estrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D006542 MUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesepeake Drive, But Air, Maryand 21014 500 W/RE tister, MD 31. Date filed (Month, Day, Year) State **JAN 2 4** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 19^{ay} 2012 Year James T. Kane Jr. January 9:40 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Gilchrist Hospice Baltimore If Under 1 Year If Under 24 Hrs. **Funeral** . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Hours (Month, Day Year) Director 212-26-9604 Yrs 82 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD 1- Yes 2 □ No Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1313 Hull Street 21230 items 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ŏ 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 MNo Specify. 'natural", 3 ₩ Widowed 4 □ Divorced Specify: White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Railroad Worker B & O Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. ೭ James T. Kane Sr. Beulah Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Kane Molander / Daughter 326 Locust Thorn Court Millersville, Md. 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) oudon Park Cemetery 1/23/12 Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Phe umonia disease or condition resulting in death) WECKS Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed trans and that initiated events resulting in death) Last Due to (or as a consequence of) ate has been signed by the attending physician a page 2 should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 1 ☐ Yes ≥ L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No -3 → Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death e Funeral Director. After this certificate has autopsy performed? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 🗌 Yes Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) VWSQLA 28a. Date of injury (Month, Day, Year) Manner of Ceath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST TONSON MM UNIVES w 6201 N

31. Date filed (Mo

JAN 2 4 2012

State

Registrar

M DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elsie Clara Leonard January 23, 2012 10:00A. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore County Towson Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 219-22-7881 1 M 2 X Months Davs Hours March 14,1927 Baltimore, MD. **Director** 84 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore County Timonium 1 Yes 2 XNo 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2102 Tree Lane Examiner must I 21093 United States Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 9 þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes If Yes, Give 2 XNo "natural", 3 ₺ Widowed 4 □ Divorced 1 Yes 2 XNo Specify: White Completed Specify Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) **N/A** life, DO NOT use retired) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Isensee Minnie Ellen Webb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2102 Prop Lane Pimonium, Maryland 21093 19a. Informant's Name/Relationship (Type, Print) (Son) f Health aitem 27 i Mr.Robert Charles Leonard, Jr. 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Baltimore County) 1 Burial 2 Cremation 3 Removal from State Carretary or other place)
Carretary
Carretary Thursday 4 Donation 5 Other (Specify) Jan. 26, 2012 Rossville, Maryland 21. Signature of Funeral Service Licensedeffrey L.Gair, Sr. OS 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093-2215 Lic.#M00677 Leres the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final schemic Provinciany disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Divide (or as a nonsequence or, cause. Enter Underlying Exami Cause (Disease or linjury that initiated events and resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Day Year been signed by the should be detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? certificate 1 Yes 2 No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2√0 No ၉ Other: 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) filled in by the funeral Manner of Death 28b. Time of Certificate: within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Tes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

6701

MA

Registrar's Signa

N. Charles ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) JAN 2 4 2012

29d. Date signed (Month. Day. Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible amend 30, per DVR, g923 1-24-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:05 AM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINITO OINLY MONTGOM Year If Under Date of Birth **Funeral** Months Days Hours Min. 19 1th, 099 Director or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1. Yes 2 □ No MON ON 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 4011 Ko KOOC 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc., þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Asian 1 ☐ Yes 2 🗹 No If Yes, Give Year or Dates Specify Specify: Completed 3 ₩Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OMESTIC Housewite Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ 19b. Mailing Address (Street and Nymber or Rural Route <u>Number, C</u>ity or Town, State, Zip Code) **7**088 19a. Informant's Name/Relationship (Type, Print) aug/182 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State -2012 Donation 5 Other (Specify) Signature of Funeral Service Licensee 10 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Chysician** disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 month signed by the atte Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗷 No 3 □ Probably 4 □ Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 100 Inpatient 2 ER/Outpatient 3 DOA 욘 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year) d address of person who completed cause of death (Item 23a) (Type, Print) Montgomery General Hospital Raphae1 Loutoby State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	te of Marylar		artment of H			2012	01451
	Physicia	an/	Decedent's Name (First, Middle, Last)	odore L.	Leach		Joann	2. Date of Death		3. Time of Death
100	Medi Exami		4a. Facility Name (if not institution, give street ar		Deaci.	4b. City, Town, or	Location of Dea		20, 2012 4c. County of Dear	2:50 A M
تسهبوات	<i>K</i> , ,		Gilchrist Center Ho 5. Social Security Number 6. Sex			Colur			Howar	·d
*	Funeral Director		215-52-1754 1 X M 2	7. Age (In yrs.)	rast birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min		Year) Co	thplace (State or Foreign untry) ryland
	show d at	ŏ	Usual Residence of Decedent 10a. State 10b. County		ty, Town or Lo	cation		1100 21,	1991 130	10d. Inside City Limits
	e Mary r 28a-f notifie	Director	MD Baltimor	5		Catonsv:	ille			1 🗆 Yes 2 🔀 No
	with th	Funeral	14 Union Hall Court			10f. Zip Code	1228	10	og. Citizen of What Co USA	
10	or item	by Fur	_ xz Arm	Decedent Ever in U.sed Forces?		Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
0036	urs afte tural", al Exan	ted b	3 ☐ Widowed 4 ☐ Divorced If Year	s, Give or Dates.		☐ Yes 2 🔀 No	Specify:		Specify: Wh	ite
215-	n 72 ho an "na' Medica	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Colli	leted) ege (1-4 or 5+)	(Give	lent's Usual Occupa kind of work done of NOT use retired)	ation luring most of wo	rking	6b. Kind of Business/	Industry
121	d withi	Be Co	12	···ge (1-4 0/ 3+)	Ware	house Mar			Office Fur	niture
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	일	17. Father's Name (First, Middle, Last) Cecil Lea	c h			18. Mother's Na Doro	me (First, Middle, Ma thy	^{aiden Surname)} Labor	ite
Mar	2 shoul th and the strain that		19a. Informant's Name/Relationship (Type, Print) Rose M. Leach, wife			g Address (Street a			City or Town, State, Zip ille, MD	21228
ore,	e 1 and of Hea If item or other		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3 □ Remova	from State 20b. F	Place of Dispo	sition (Name of natory or other place	1		Oc. Location - City or	
Itim	artment ortant: injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ge	Me ⁻	tro Cre	ematory,	Inc. 01/	/21/12	Baltimore	, MD
Ba	permir Depar Impor any in		Sleon EMa	Me Haciva	100	299 Frede	erick Ro		timore, MI	
1	Physician Medical Examiner		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	that caused the death on each line. A A A A A A ue to (or as a consequ		35		or respiratory arrest	t,	Approximate Interval Between Onset and Death APRIL 2011
*	ted	Examiner	Cause. Enter University Cause (Disease or injury	ue to (or as a consequ	uence of):					
	ate be executed hysician and the burial-transit	dical Exa	that initiated events c	le to (or as a consequ	uence of):					
68760	ificate big phys	Medic	d							
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Puneral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	s, outcome of pregna Live Birth 2 Feta Pregnant at time of d Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)	·		23d. Date of del Month	very Day Year
ds, P.O	requires that the dex been signed by the s should be detached	by	Part II. Other significant conditions contributing	to death but not res	ulting in the u	nderlying cause give	en in Part I.		cco use contribute to	the cause of death?
Records, P.O.	The law rectate has been page 2 sho	Completed						24a. Was an autopsy performe	prior to death?	opsy findings available ompletion of cause of 2 No
lita	ysician: is certific director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No Hospital:	101	FF.10	Otho	ce of Death (Che			HOSPICE
ot	ng Phy fter this uneral c	ate: To	27. Manner of Death 28a.	1 Inpatient 2 In	28b. Time of injury	28c. Injury	4 □ Nursing F at	dome 5 Residence 28d. Describe how	ce 6 X Other (Speci injury occurred	MOSPICE
Division of Vital	Io the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	Place of Injury - At ho	me, farm, stre		Yes 2 □ No		et and Number or Rur	al Route Number,
2	pital or ours afte eral Dir filled in		29a. Certifier 1 Certifying Physician: To	building, etc. (Specify)				City or Town, S		
	the Hos hin 24 h the Fun npletely	Medical	(Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Practit	e basis of examination	and/or investi	gation, in my opinior	n. death occurred	at the time, date and i	place, and due to the o	ause(s) and manner stated
	Note that the second se		29b. Signature and title of certifier	1)	~	29c. License		290	d. Date signed (Month)	Day, Year)
•	100h		30. Name and address of person who completed DANIEUE DOBLEMAN	cause of death (Item	23a) (Type, Pr	int)	LANE	EOWEMA	TANUARY 2 314, MS	21044
	Stat Registra	e ır	JAN 2 4 2012	32. Registrar's Signal	ure		10000			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOI 8. Date of Birth (Month, Day, Year) Birthplace (State or Country) Age (In vrs. last birthday) **Funeral** Director KOREA 12-15-28a-f show notified at 10d. Inside City Limits **Funeral Director** 1 Yes 2 □ No must be items 23a U514 0910 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, the Medical Examiner ö Completed by 1 Yes 2 If Yes, Give Year or Dates. 1 Yes 2 No "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) Elementary/Secondary (0-12) other traumatic event, Be 17. Father's Name (First, Middle, Last) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည (Type, Print) / RUS LITE 19b. Mailing Address (Street and Number or Baltimore, Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner and been signed by the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death
Unknown Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown IPIDEMIA Were autopsy findings available prior to completion of cause of death? autopsy ☐ Yes 2 ☐ No To Be 25. Was case referred to medical examiner?
1 \(\sum \) Yes 2 \(\sum \) No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending Division ☐ Accident ☐ Suicide Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd. Bethesda, MD, 20886 Natalia Vasquez Martinez Registrar

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ^{Year} 2012 12:14 A M Anna Catherine Ling Jan. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkville Balto. 3538 Woodring Ave. 8. Date of Birth (Month, Day, Jan. 9 If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 X F Days Hours 1927 Director 85 198-20-6976 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits death with the Maryland Examiner must be notified at Director 1 Yes 2 X No MD Balto. Parkville 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 21234 USA 3538 Woodring Ave. items 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ģ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. white Completed Specify 3 X Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Balto. County Schools 10 Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Grace Marie Cable Augusta Dickert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3538 Woodring Ave., Parkville, MD 21234 Candice Adkins/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1/26712 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) injury or <u>Dulaney Valley Memorial Gardens</u> Timonium, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 H Padonia Rd. Timonium, MD 21093 21. Signature of Funeral Service Licensee any Michael **Flagle** 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Demin 400 years Medical Due to (or as a consequence of) Examiner myscardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to or as a conse uence of: the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 attending pl IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 ☐ Yes 2 💢 No 9 ☐ Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed?
1 ☐ Yes 2 🗶 No 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

State Registrar 29a. Certifier

(Check

only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1205

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00040208

ork Rd Ste 32c Lutherville md 21093

29d. Date signed (Month, Day, Year)

23

29c, License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perINF, G923, 1731/2012, WS
State of Maryland / Department of Health and Mental Hygiene 2 1 2012 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2 Pay Johnette Η. Lange Jan. 2012 7:45р м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Heritage Center Dundalk yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 218-18-8239 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country 1 🗆 M 2 🔀 F NOV . 23 Months Hours Min. Director ∜923 Usual Residence of Decedent or 28a-f show 10a. State 10b. County with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7543 Berkshire Road 21224 USA or items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White Specify: "natural", Completed 3 Nidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
Homemaker permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) own home 9th other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname)
Lucille 17. Father's Name (First, Middle, Last) Adam Hess 19a. Informant's Name/Relationship Type Print StarkTauf Shari L. Starklaut 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) /daughter P.O.Box70024 Baltimore MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 **Cremation 3 ** Removal from State 4 Dopation 5 ** Other (Specify) any injury or Bayview Crematory 1/23/12 Baltimore MD 21. Signay re Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee shock, or heart failure. List only one cause on ine Immediate Cause (Final Orpor and Real Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 01 Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregr 23d. Date of delivery 3

Ectopic pregnancy in the past 12 mont Month Day Year Pregnant at time of death 5 Other (specify) signed by the aid be detached for Unknown Unknown to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Yes 2 certificate 1 Yes 2 No Yes 25. Was case referred to mer cal funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Mann f Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be De. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determine City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature of certifie 101 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of		epartment of		Mental Hygie	2012	01455
	Physic	ian	1. Decedent's Name (First, Middle	e, Last)	LEE			2. Date of Death Month	Day Year	3. Time of Death
á	/Medi Examir	-	4a. Facility Name (If not institution	77/Y n, give street and numb		4b. City, Town,	or Location of Deat	/ - Z.	4c. County of Death	12:05 AM
		di	LORIEN / 5. Social Security Number	HEALTH 6. Sex 7.	CARL Age (In yrs. last birtho	1000	mbill r If Under 24 Hrs.	MI)	How.	ARCI
	Funeral Director		216-21-2306	120 M 2□ F	79 Yr	Months Day		8. Date of Birth (Month, Day, Ye	32	pplace (State or Foreign intry)
	Maryland e-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County MD MN//2	- ARU NSOL	10c. City, Town o	r Location SA SE	NA			10d. Inside City Limits 12 Yes 2 □ No
	ath with the 23s or 28 ust be no	Funeral Director	10e. Street and Number 2388 20	ckwa	d Rd	10f. Zip Code	122	10g.	Citizen of What Co.	untry?
5-0036	init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland entment of Health and Mental Hygiene. critent: If item 27 is marked other then "netural", or Items 23e or 28e-1 ehow injury or other treumatic event, I've Medicul Examiner must be notified at its.	by	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	If Yes Give	No	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🔏 No	ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0	within 72 ho ene. then "netu	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4)	(0	ecedent's Usual Occi Rive kind of work don te. DO NOT use retir	e during most of wor	rking 16b	Kind of Business/I	ndustry
	be filed withintal Hygiene. Id other therevent, the N	Be Co	17. Father's Name (First, Middle,	Last)	1 6	-014/12	18. Mother's Nar	ne (First, Middle, Maid	len Sumame)	140
Maryland	should be and Mental I marked o	To	KYUNG	YOON	6	E	Ah	1.6	<td>7</td>	7
_	1 and 2 sho Health and Iem 27 is ma		YOUNG /	hip (Type, Print) M - DAUG	inter \$	3 & & Loc	et and Number or Ru	Ral Route Number Cit	y or Town, State, Zi	ip Code) Z//Z/
Baltimore,	Pages 1 and of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 □Removal from Sta	20b. Place of D	sposition (Name of crematory or other pl	ace)/	Date 25	Location - City or T	Wm, State
Balti	permit. Page Depertment of Importent: If any njury or or e.		21. Signature Sevice	Licensee	1	22. Name and Add	ress Facility Ho	uslefyn	FRACT	tome
			23a. Part1. Earer the disease, or shock, or heart failure. List	complications that caus	sed the death. Do not	enter the mode of dy	ring, such as cardiac	or respiratory arrest,	1550 P.M	Approximate
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. As	PIRATI	ow	ANEUM	IONIA		Interval Between Onset and Death
	/Medical Examiner				as a consequence of):					
	led .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequence of):					
90,	be executed sician and burial-transit		that initiated events resulting in death) Last	c. Due to (or	as a consequence of):					
68760,	ficate by physicas the b	edicai		d						
.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death	3 □Ectopic pregnant 5 □ Other (specify)	су		23d. Date of deliv Month	very Day Year
rds, P.	quires that the de n signed by the a uld be detached f	by	Part II. Other significant condition	ns contributing to death	n but not resulting in th	e underlying cause g	iven in Part I.	23e. Did tobacc	o use contribute to	
		Completed						24a. Was an autopsy performed 1 Yes 2	prior to co	opsy findings available ompletion of cause of
Vita	sicien: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		0	thor	th (Check only one)		
of	ing After une	tion: To	1 Yes 20 No 27. Manner of Death Natural 5 Pending 2 Accident investig	28a. Date of Ir (Month, L	atient 2 ER/Outpa njury 28b. Tim Day Year) Inju	e of 28c. Injury	4 Nursing H	ome 5 Residence 28d. Describe how in		ify)
Ź		Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 256. Place of	Injury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (Street City or Town, St		al Route Number,
	To the Mospitel or within 24 hours after To the Funerel Discompletely filted in	edical (29a. Certifier Check only one) Certifying	g Physician: To the be Examiner: On the basis and manner	of examination and/o	eath occurred at the trinvestigation, in my	ime, date and place opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the be within 24 To the 6 complete	Med	29b. Signature and title of certifier	and manner	Stateu.		se number		Date signed (Month,	
	has		Ship	MD		000	053157	D JE	IN 215	1 2012
_	70			ALA GO	UPTA	9650	SANT	JAGO B	O %	0 LU mbi A
	Sta Registr	9	31. Date filed (Month, Day, Year) JAN 2 4	2012	strar's Signatura	Barles				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Nancijane Lamberger Jan 2012 11:55P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore Co. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 5, **Funeral** 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 🗆 M 2 😾 f ^{Year} 37 Director 187-30-9250 Pennsylvania 74 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Directo 1 Tyes 2 X No MD Baltimore Dundalk 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 7630 Charlesmont Road United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. of Health and Mental Hygiene.
item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner! 11. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 Married ò Yes 2 No Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Specify. 3 Widowed 4 Divorced Completed White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Title Company Typist Be Department of Health and Mental Hy Important: If item 27 is marked any injury or and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Emmett Gallagher Vera Hodgson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane C. Rainier(Daughter) 7630 Charlesmont Road Dundalk, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurlal 2 Cremation 3 Removal from State South Side Cemetery 1/20/2012 Pittsburgh, PA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) TAT Medical ue to (or as a consequence of) Examiner pholic Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 Urknown Unknown Division of Vital Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 Mo 3 ☐ Probably 4 ☐ Unknown cate has been siç ; page 2 should b Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 Yes Yes Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ieral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending after death. M Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 24 hours a Medical 29a. Certifier 🚝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 29b. Signature and title of certifier 10 CO 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

\0 √

Registrar

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	arylan	d / Depa	artment of I	-lealth	and Mo	ental Hy	giene			
_			State Registrar			Cer	tificate of l	Death			Reg. No. 2	112	0.145	7
ı	Physicia Medi		1. Decedent's Name (First, Middle, La	,	athle	en Lu	ckert			2. Date of Dea Jan	18,	2 ^{Year} 2	3. Time of Death 10:00 P M	
Long	Examin	ner	4a. Facility Name (if not institution, giv				4b. City, Town, o	r Location o	of Death		4c. Count	y of Death		
-			Genesis Heritage 5. Social Security Number 6.			ng Hon	e If Under 1 Year	Dunda				Baltim		
	Funeral Director		216-18-4796	1 M 2 WE	87	Yrs.	Months Days	If Under Hours	Min.	8. Date of Birtl (Mo <i>nth</i> , Day) 1u1y 27	(, Year)	Count	lace (State or Foreign ry) inia	
	nd how at	5	Usual Residence of Decedent 10a. State 10b. County			, Town or Loc	ation		<u> </u>	diy 27	,1727	-	Od. Inside City Limits	_
	faryla 3a-f s tified	Director	MD Ba	ltimore			nda1k						1 Yes 2 X No	,
	or 28	直	10e. Street and Number	ILIMOTE		Du	10f. Zip Code				10g. Citizen of	What Count		-
	with s 23a ust b	Funeral	7813 Eddlynch	Road				2122	22		_	ed Sta	,	
	death item	교	11. Marital Status	12. Was Decedent I Armed Forces?	er in U.S	. 13. W	/as Decedent of H Yes, specify Cuba	ispanic Orig	gin? (Speci	fy Yes or No-		ce - America		_
36	after (", or camir	l by	1 Never Married 2 Married	1 Yes 2 K	No		Yes 2 X No			can, etc.)	Bla Specify	ck, White, e		
8	2 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	etec	3 X Widowed 4 Divorced 15. Decedent's	Year or Dates.								WII	ite	_
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at	Completed	(Specify only highest g		,	(Give k	ent's Usual Occup ind of work done () NOT use retired)	during most	t of working	,	16b. Kind of B	Business/Ind	ustry	
212	within giene er th	ပို	9 Years	College (1-4 or s	0+)		aitress				Resta	urant		
nd	tal Hy d oth	To Be	17. Father's Name (First, Middle, Last)	Unkn.				18. Mothe	er's Name (First, Middle, I	Maiden Surnam	e)		
Ş	2 should be filed within 72 hours in and Mental Hygiene. 7 is marked other than "natural traumatic event, the Medical Extraumatic event e	٦			Shif	let		E	verin	e Shif	let			_
, Maryland	- = N .		Joe Luckert (Son			19b. Mailing 7813	Address (Street a	and Numbe h Roa	er or Rural F d Du	Route Number, ndalk,	City or Town, S Maryla	State, Zip Co nd 2	ode) 1222	
Baltimore,	t of Healt item		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	ce	metery, crem	ition (Name of atory or other place		Da		20c. Location	- City or Tov	vn, State	
Iţim	it. Pag rtmen rtant; njury		□ Donation 5 □ Other (Spec	ify)	Gdn		Faith Ce		1/21/				Maryland	
Bal	permit. Page 1 Department of Important; If i any injury or once,		21. Sign Jure of Funeral Service Liver	see C	2	70	Name and Address uda-Ruck 922 Wise	Fune Ave.	ral H Dund	ome of alk, Ma	Dundal aryland	k, In	c. 22	
Н			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	one cause on each line	4					espiratory arre	est,		Approximate Interval Between	1
	Physician/ Medical	Y.	Immediate Cause (Final disease or condition resulting in death)	a Acu	TE	KEN	IAL FA	IWI	RE				Onset and Death	
100	Examiner		Todailing in ddairi,	Due to (or as a	conseque	ence oi):	HYDK							
		ner	S quentially list conditions if any, leading to immediate	b. Due to (or as a			MUSK	71/	774					\dashv
	ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	· DEM	DEN	TIA								
	ate be executed ohysician and the burial-transit	a E	resulting in death) Last	Due to (or as a			2							
	ate be ohysic the b	dical		d	CKI	EN	510N							4
687	death certific	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan	cv		-						٦
Вох	atten aften d for u	iciar	in the past 12 months?		2 🔲 Fetal	death 3	Ectopic pregnanc Other (specify)	У				te of deliver onth [y Day Year	
_	the de	Physician/M	9 Unknown	9 Unknown										
P.0	res that the death certific. signed by the attending p d be detached for use as	by	Part II. Other significant conditions of	ontributing to death b	ut not resul	Iting in the un	derlying cause giv	en in Part I.		23e. Did tob	pacco use cont	ribute to the	cause of death?	
ð,	been signatures	ted							— II	1 □ Ye	es 2 🗆 No	3 🗌 Proba	ably 4 Unknown	Ŋ
Division of Vital Records,	law re has be e 2 sh	Completed								24a. Was ar autops	sy L i	prior to com	sy findings available pletion of cause of	
Re	t: The cate l									perform	ned?	death? 1 🗌 Yes 2	No	
ita	sician certif irecto	m	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Otho		ly (Check or	nly one)				\dashv
of V	y Physer this eral d	e: To	27. Mann of Death	28a. Date of injur	у 2	R/Outpatient 8b. Time of	3 DOA 28c. Injury	4 Nu			nce 6 Other			4
nc	nding ath. r: Afte ie fun	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	Year)	injury	work'	? Yes 2□	- 1	a. Describe no	w injury occurr	Bu		
/isi	er der er der rector	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of Inju	ry - At hom	ne, farm, stree	t, factory, office		28		reet and Number	er or Rural R	Coute Number,	1
Ö	ital or irs aft ral Dir lled in			building, etc						City or Town				ļ
	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Medical	(Check 2 \square Medical Exam	sician: To the best of a iner: On the basis of ex	camination a	and/or investig	ation, in my opinio	 n. death occ 	curred at the	time date and	diplace and due	to the caus	e(s) and manner stated	J.
	To the vithin To the complete		only one) 3 ☐ Certifying Nur 29b. Signature and title of certifier	se Practitioner: To the	best of my	knowledge, a	eath occurred at the 29c. License	ne time, date	e and place,	and due to the	e cause(s) and n 9d. Date signed	nanner as sta	ated.	\dashv
	- > - 0) (mindo	11151	000.	MIN	1.02	718	8		1 - 71	7 - 12	,, , , , , , , , , , , , , , , , , , , ,	
		}	30. Name and address of person who	completed cause of de	eath (Item 2	3a) (Type, Pri	nt)	10	,		,	, ,	21222	\dashv
2	Stat		31. Date filed (Month, Day, Year)	C Jully	2 r's Signatu	Ma	mers!	1 ac	el	lund	all	MD	21222	
	Registra		JAN 2 4 20	12 Deser	, A.	par	w	_						

12-00453 Brian Lemley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Brian Lemley	S 1- For State Registrar	tate of Marylar		artment of		d Mental	,,	teg. No. 20	12 0145
Physiciar Medical Examin	 Decedent's Name (First, Mide 	tthew Lemle					2. Date of Dea Month January 1	ath Day Year	3. Time of Death 1005 hrs
	4a. Facility Name (if not instituti Suburban Hospital	on, give street and num	ber)	41	. City, Town, or Bethesda	Location of De		4c. County of D	
Funeral Director	5. Social Security Number 230-49-5109	6. Sex 7	. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Day				Birthplace (State or or oreign Country) Canada
any	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locatio	1				10d. Inside City Limits
uryland Sa-f show st.once.	Maryland Mont 10e. Street and Number 2928 Greenvale	gomery			Chevy Cl	hase		0g. Citizen of What	1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once	2928 Greenvale		Ind Francis III		208	815		United S	States
	1 X Never Married 2 N 3 Widowed 4 Div	larried Armed Force 1 Yes vorced If Yes, Give Year or Dates:	es? 2 X No	If Yes	, specify Cubar	specify:		White, et	merican Indian, Black, c. hite
24 3 3 3	Elementary/Secondary (0-12)				of working life	. DO NOT use r		16b. Kind of Busine	ŕ
	12 17. Father's Name (First, Middle Barry M. Le:	, ,		Contrac	t Worke	18.Mother's Na	me (First, Middle, I	Maiden Surname)	Government
D 2121 should be fi and Mental J ? is marked natic event,	Barry M. Le 19a Informant's Name/Relations Barry M. Lem1	ship (Type, Print)		19b. Mailing A	ddress (Stree	t and Number o	oria J. E	nber, City or Town, S	tate, Zip Code)
ore, M s 1 and 2 of Health If item 2	20a. Method of Disposition 1 Burial 2 X Cremation	<u> </u>	20b. P	Place of Disposition	n (Name of cer			20c. Location - City	-
Baltimore, permit. Pages l ar Department of Hee Important: If ite	4 Donation 5 Other S 21. Signature of Funera) Service	pecify:	Cre	matoriún	, Inc.		D12 bert A.		, Maryland Funeral Home
Physician	23a. Part I. Enter the disease, or	complications that caus	MO1	498 Beth Do not enter the	mode of dying,	aryland	or respiratory arre	st, shock, or heart	Funeral Home consin Avenu
/Medical Examiner	failure. List only one cause Immediate Cause (Final diseese or condition resulting in death)		e Diso				· .		Between Onset and Death
	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of):					-
ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of)):					
0, e be executed sician and burial - transit	X UNPENDED	d AMENDED	23a,27	per me	g925 3-	28-12 v	7t		=
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate by the Funeral Director: After this certificate has been signed by the attending physinapletely filled in by the funeral director, page 2 should be detached for use as the buildeal Certification: To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 University	I I LIVE DITUI	at time of dea	2 Fetal	death 3 [Ectopic preg	nancy	23d. Date of delive Month	very Day Year
ires that the direct that the disagned by the lbc detached by the detached by the detached by Physical				sulting in the und	erlying cause gi	ven in Part I.			to the cause of death?
of Vital Records, P.O ag Physician: The law requires that the three this certificate has been signed by meral director, page 2 should be detact. To Be Completed by F.							24a. Was a	n 24b. Were	robably 4 V Unknown autopsy findings available o completion of cause of
tal Rection: The I certificate bector, page					26.Place	of Death (Chec	perform 1 ✓ Yes 2 k only one)	med? death 2 No 1	
of Vital Physician Physician er this certi	1 Yes 2 No	Hospital: 1 Inpa		ER/Outpatient 3	DOA C	Other Nurs	sing Home 5 1		her:
sion o Atending death. ctor: Aft y the fune	1 Natural 5 Pend 2 Accident Inves	(Month, Day	y,Year)	20b. Time of Inju	· ·	at Work?	26d. Describe n	ow injury occurred	
Division or To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Gertification:	3 Suicide 6 Could 4 Homicide	d not be mined 28e. Place of (Specify)	Injury - At hor	ne, farm, street, f	actory, office bu	ilding, etc.	28f. Location (S or Town, St		Rural Route Number, City
To the Hos within 24 h To the Fun completely		ysician: To the best of niner:On the basis of ex and manner state	kamination and	e, death occurred d/or investigation	at the time, dat in my opinion,	e and place, an death occurred	nd due to the cause I at the time, date a	e(s) and manner as s and place, and due to	ated. the cause(s)
	29b. Signature and title of certifier	111	19		29c. License O.C.M			29d. Date signed (A	
pend	30. Name and address of person Zabiullah Ali, M.D.	ssistant Medical I	Examiner	900 W. Ball	imore Stree	t, Baltimore	e, MD 21223		
State Registra		Server 32. Regist	ra's Signature	Mad					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2D12 Month Day VIOLT 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NIT Lryigaton 8. Date of Birth last birthday) If Under Birthplace (State or Foreign Country) 1 □ M 2 🗷 F Months 216-56-1699 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside Sity Limits Baltimore 1 Ves 2 No Marykind 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) omemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mae Dickerson 19a. Informant's Name/Relationship (Type. Print) Battinos 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MOXIC brain Due to (or as a consequence of): ardiopulmonar Sign initially structions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): em 00 Due to (or as a consequence of): IF FEMALE: 23d. Date of delivery pregnancy Month Day Year specify) cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ossiticalia 1 ☐ Yes

Physician /Medical Examiner the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Director

by Funeral

Completed

Be

ပ

Examiner

Funeral

Director

ortant; If item 27 is marked other than "natural"; or items 23a or 28a-f show injury or other traumatic event, the Modical Exa of our context our exiting all

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked oth any injury or other traumatic event

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine Physician/Medical Be Completed by Certification: To

23b. Was decedent pregnant in the past 12 mm ths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 İ 4 İ	Unknown	
Part II. Other significant conditions			g in the underlying
Anemia of chro	nic	inflammation	ρŊ
A 1	1	\wedge \wedge \wedge	

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Mursing Home Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier
(Check only
one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

028462

29d. Date signed (Month, Day, Year) 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boston

S 31. Date filed (Month, Day, Year)

State Registrar

Medical



DHMH 17 Rev 1/2001

After this funeral dir

24 hours after death Funeral Director:

within 2 To the F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and numb **Examiner** City, Town, or Location of Death 4c. County of Death Baltimore edera . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign -9925 Hours Min **Director** 1 M 2 XF 10/21 28a-f show 10a, State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD 1 X Yes 2 No timore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces Completed by 1 Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 Yes 1 ☐ Yes 2 K No Specify. If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: Black Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College,(1-4 Elementary (Secondary (0-12) Schools Food Baltimore Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Jackson 1010 Informant' Name/Relationship (Type, Print) 19a 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore YN DAle andra 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Bervice Licensee 22. Name and Address of Facility March FIH East 1101 Brunk Mr Rui 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of, burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death 2 No the 9 Unknown Unknown Division of Vital Records, P.O. signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy 2 🗌 No 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 2 No Accident Investigation within 24 hours after death

To the Funeral Director:

completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

DHMH 17 Rev 06-2011

State Registrar son who completed cause of death (Item 23a) (Type

Day 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ dan VO NALO Medical Examiner 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death 17715 Prettyboy Dam Rd Baltimore Parkton Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Director** 220-42-7061 **X**X M 2 □ F 67 Sep.15,1944 Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes XX No MD Baltimore Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 17715 Prettyboy Dam Rd. 21120 12. Was Decedent Ever in U.S. Armed Forces?

All Yes 2 No1 969 - If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2XXMarried ld be filed within 72 hours after Mental Hygiene. arked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates. 1975 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Field Test Engineer Black & Decker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Virginia Rill Page Walter Mays and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a 17715 Prettyboy Dam Rd. Parkton, MD 21120 Debra Hale Mays / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot Page 1 XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 1/25/12 Manchester, MD New Lutheran Cem. 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Fundal Arvice Licensee 3296 Charmil Dr. Manchester, MD 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physiciani disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical law requires that the death certificate be Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Pregnant at time of death 2 No the 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown been signed by to should be detach Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 performed? certificate 1 🗆 Yes 2 🗆 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Hospital or Attending Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 06-2011

ise of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. Pay 2012 4:50р м Bernice T. Martin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Longview Nursing Home Manchester Carroll 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔽 F Min. Hours A (1914), Pay, Year) 191 Country) Marvland 217-16-8589 99 **Director** Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Manchester 1 Yes 2 Xio 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 2607 Mindi Drive 21102 items Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 ♥ Widowed 4 □ Divorced Specify: White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Lovell Taylor Mary Lulu Amanda Dehaven 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leona M. Eckert (Daughter) 59 Hardwick Ln., Wayne, NJ 07470 20b. Place of Disposition (Name of cemetery, crematory or other place) J a n 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite 20c. Location - City or Town, State Date injury or 1 X Burial 2 Cremation 3 Removal from State 24,2012 4 Donation 5 Other (Specify) Evergreen Mem. Gardens Finksburg, MD. 21. Signature of Funeral Service Licenses any in once. 22. Name and Address of Facility Eckhardt Funeral Chapel P.A · Huls Elles Dr. Manchester, Charmil 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Onset and Death recourscular disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ been signed by the atte should be detached for in the past 12 months? Month Pregnant at time of death Day Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No To the Hospital or Attending Physician; filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗆 No Accident Investigation Could not be 1 Yes Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Amend 8, 9, per FD g923 1/24/12 amh
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 For State		laryland / Dep	artment of ⊢	lealth and M	•	_	011.61.
			Registrar 1. Decedent's Name (First, Middle	a / act)	Ce	rtificate of E	Death T		No. 4 U 1 4	01404
	Physicia Media		Janet	Marie	Mealey			2. Date of Death Month January	Day Year 20.2012	3. Time of Death
Aug	Examir		4a. Facility Name (if not institution	, give street and number)		4b. City, Town, or	Location of Death	Jamary	4c. County of Death	
4			Gilchrist Hos			Columb			Howard	
	Funeral Director		5. Social Security Number 026-24-1047	6. Sex 7. Ag	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth Cou.	nplace (State or Foreign ntry) Mass
	T M	1.	Usual Residence of Decedent					Nov. 25	193 lass	achusetts
	nyland I-f sho ied al	cto	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 Yes 2 No
	he Ma or 28a or 01if	Dire	MD Howar	<u></u>	Columbi	a 10f. Zip Code		100	. Citizen of What Cou	
	with t	Funeral Director	7080 Cradler	cock Way	apt 516	21045			U.S.A.	andy:
	death items ner m	ᇤ	11. Marital Status	12. Was Decedent I Armed Forces?			spanic Origin? (Spec n, Mexican, Puerto R		14. Race - Ameri	
36	after (II', or xamir	d by	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 Yes 2 M	No	1 ☐ Yes 2 🛣 No		iodii, etc.)	Black, White,	
8	atura ical E	letec		Year or Dates.	16a Dece	dent's Usual Occupa	ation	161	Specify: Whi	
21215-0036	in 72 le. nan "r Med	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4 or 5	(Give		uring most of workin	g Tot	o. Kiliu of Busiliess/li	ldustry
21	d with lygien ther th	Be C		2		ewife		0,	wn Home	
Maryland	mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland entment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	To B	17. Father's Name (First, Middle, I Joseph	Last) Greene	9		18. Mother's Name Helen	(First, Middle, Maid	den Surname) Murp	hy
lary	should and N is ma		19a. Informant's Name/Relations	hip (Type, Print)	19b. Maili	ng Address (Street a	nd Number or Rurel	Route Number, City	y or Town, State, Zip	Code)
	ind 2 selection m 27 there tra		Elaine Lodge	e daughter	<u> 701</u>	<u>S.Cherry</u>	Grove	Ave. A	nnapolis	21401
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra	3	20a. Method of Disposition 1 M Burial 2 Cremation		20b. Place of Dispo cemetery, crei	sition (Name of natory or other place	Da	ate 200	Location - City or T Garriso	own, State on Forest
Itin	artmer ortant injury	1	4 ☐ Donation 5 ☐ Other (\$ 21. Signature of Funeral Service I	· · · · · · · · · · · · · · · · · · ·	IMD VA C			26 2011	Mary	
Ba	permii Depar Impor any in		> (No With				Tally Wi			Cremation
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused	the death. Do not ent	er the mode of dying	, such as cardiac or	respiratory arrest,		Approximate Interval Between
nki.	Physician/		Immediate Cause (Final disease or condition	comi		NS OF E	SOPHAJE	AL STRI	MURE	Onset and Death
9	Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
	te be executed nysician and he burial-transit	E	resulting in death) Last	Due to (or as	a consequence of):					
,60	ate be ohysic the bi	Physician/Medical		d						
9289	eath certificate b attending physic d for use as the b	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				Old Date of deli-	
Вох	eath c atter d for u	iciai	in the past 12 months? 1 Yes 2 No	4 🔲 Pregnant a	2 Fetal death 3 time of death 5	Ectopic pregnancy Other (specify)			23d. Date of delive	Day Year
P.O. E	t the d by the	Phys	9 ☐ Unknown	g 🔲 Unknown						
о. С.	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transi		Part II. Other significant condition	ins contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.		co use contribute to t	he cause of death?
ords	requir been should	letec	EMPHYSEMA					24a. Was an		ppsy findings available
of Vital Records,	The law ate has page 2:	Completed by	LUNG CANCER	-				autopsy performed	prior to co	empletion of cause of
al B	ician: The certificate rector, pag	o l	25. Was case referred to medical			26. Pla	ce of Death (Check o	I 1 ☐ Yes 2 🔀 only one)	No 1 ☐ Yes	2 LI No
<u>Xi</u>	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 🔲 Inpatie	ent 2 ER/Outpatier	ot 3 DOA Other	4 ☐ Nursing Hom	ne 5 🗆 Residence	6 X Other (Specify	HOSPICE
0	ding P	ate:	27. Manner of Death1 Natural5 ☐ Pendin			28c, Injury work?		3d. Describe how in	njury occurred	
Siol	Attending P or death. ector: After t by the funera	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be	ry - At home, farm, stre		′es 2 □ No	Rf Location (Street	and Number or Rura	I Route Number
Division	al or saftel		4 L Homicide determ	building, etc		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, Sta		rroate (vambor,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process.	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of ex	xamination and/or invest	igation, in my opinior	, death occurred at th	ne time, date and pla	ace, and due to the ca	use(s) and manner stated.
	To the I within 2 To the I complet		only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practitioner: To the	e best of my knowledge,	death occurred at the	e time, date and place	e, and due to the ca	use(s) and manner as	stated.
0	F ≤ F ŏ		1	50/)) (-) //	4395	- Zad.	ANUARM S	20, 2012
			30. Name and address of person v	who completed cause of de	eath (Item 23a) (Type, F	rint)			1	
Į.) \		DANIEUE DO	BERMANIM			LANE	coume	BIA, MS	21044
	Stat Registra	.6	31. Date filed (Month, Day, Year) JAN 2	32. R 315.		arke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MORGAN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death WELL MOV If Under 1 Year 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Month, Day, Ye Jan 23 78 Hours Min Country) India **Director** 216-48-3411 1932 Usual Residence of Decedent la or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Harford Bel Air 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral the Medical Examiner must 21014 United States 225 B Crocker Drive or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: e 1 and 2 should be filed within 72 hours after tof Health and Mental Hygiene.
If item 27 is marked other than "natural", If Yes Give Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools School Bus Attendant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Jenkins Eunice Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Miller /Friend 225 B Crocker Drive Bel Air, MD 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date any injury or 1 Burial 2 Cremation 3 Removal from State .25.201 Important Baltimore, Maryland 4 Donation 5 Other (Specify) Mount Carmel Cemetery 21. Signature of Funeral Service Licensee 22. Narchartison Familia Funeral Alternatives Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the burial-transit that initiated events resulting in death) Last Due to (or physician Physician/Medical for use as f yes, outcome of pregnancy

Live Birth 2
Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months' 1 Yes 2 No Month Dav Year signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death. Accident
Suicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, d at the time, date and place, and due to 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1123 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MY 21234 FERNANS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death Day 2012 Physician/ Month Richard Randolph McMahon, Sr. Jan. 19. 11:50 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Howard Columbia Gilchrist Hospice Care If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day, Year) Director 215-30-6322 1 M 2 F 79 May 15, 1932 Washington, D.C. 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Baltimore Baltimore 1 Yes 2 X No or 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral "natural", or items 23a 21229 1102 Vernon Avenue USA death Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc Completed by 1 Never Married 2 Married mit. Page 1 and 2 should be filed within 72 hours after is artment of Health and Mental Hygiene. ortant; If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examin 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2xxNo 1 Yes 2xxNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) n/a Baltimore City Computer Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph D. McMahon Letitia Brook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances McMahon / Wife Balimore, MD 21229 1102 Vernon Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Atlantic Crematory, LLC Jan. 21, 2012 Glen Burnie, MD 1 Burial 2xxCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ NORMAL PRESSURE HYDROCEPHALUS 487-5 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any leading to in medicause. Enter Underlying Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🕅 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acci 5 Pendina work? 1 ☐ Yes 2 ☐ No s after death. I Director; Aft М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral D

completely filled Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 064395 29b. Signature and title of certifier JANUARY 19, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 104 6336 COLUMBIA, MO 21044 DANIEUE DOBERMAN, MO CEDAR LANE

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 27LD NO. 143 FA 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Dove House Westminster Social Security Numbe If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1**X** M 2 □ F Months Days Hours Min 03/16/1917 **Director** 217-07**-**3606 94 MD Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Howard Ellicott City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2750 Deerfield Drive 21043 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 14 Yes 2 No 1946-Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify Completed 3 ₩ Widowed 4 □ Divorced 1947 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fil Health and Mental 2 Walter Albert Miller Sophia Bernstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2408 Forest Hill Road Marriottsville, MD 21104 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t <u>Marsha Johnson - Daughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Park Cemetery | 01/26/2012 Baltimore, MD Loudon 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician) disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner eax Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, Exami burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Month Day Year Pregnant at time of death signed by the a Id be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy this certificate 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 5 Pending injury Accident within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 🗋 Yes Investigation 2 🗌 No 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 21029 30. Name and address of

DHMH 17 Rev 7/2009

State

Registrar

Registrar's Signatu

aw

X18731 JANUARY MARRS Baltimore, Maryland 21215-0036 STREETER RISTOPHER

Funeral

Director

28a-f shov

0

23a with

items

0

"natural",

er than "natur, the Medical B

be notified

the Manyland

and Mental Hygiene. 27 Linda Dunigan Marrs/ Wife item 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once. cemeter, crematory or other place)
Montgomery
Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee shock, or heart failure. List only one cause on each lin myo cardial infarction acute Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner coronary arter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a const quence of): Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician; The law requires that the death certificate be after death. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, page 2 should Completed 25. Was case referred to medical Be examiner? 1 Yes 2 X No Other: မ 1 🗌 Inpatient 2 💢 ER/Outpatient 3 🗌 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital 24 hours Medical 29a. Certifier 29b. Signature and title of certifier DØ064235 5.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 7:11PM Christopher Streeter Marrs January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital <u>Rockville</u> Montgomery 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Months Country) 215-68-8754 Usual Residence of Deced 1 🛛 M 2 🗆 F November 23, 1955 56 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 🗌 Yes 2 💢 No Maryland Montgomery Germantown 10f. Zip Code 109. Citizen of What Country? 18960 Abbotsford Circle 20876 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces þ 1 Never Married 2 X Married ☐ Yes 2 🗓 No 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 🗌 Widowed 4 🗌 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Financial Software Programming Senior Systems Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ <u>Barbara Louise Harris</u> Don Franklin Marrs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18960 Abbotsford Circle, Germantown, Maryland 20876 20c. Location - City or Town, State 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, occamplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death hour y cars 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed' 2 No Yes 2 No 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive, Rockvilley Maryland 20850 Buzy, MD 1901 Mcdica 1001 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gloria C. Otter 11:00 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death TIMORE n/a If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Min 1 □ M 2 🔀 F Hours 10/24/1928 Director 166-22-2011 83 Yrs PA Usual Residence of Decedent or 28a-f show notified at 10a State 10b. County 10c. City, Town or Location the Maryland Director 1 🗌 Yes 2 🙀 No MD Baltimore Arbutus 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a o Examiner must be Funeral within 72 hours after death with 1215 Maiden Choice Lane 21229 USA 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: "natural" White Completed 3 Widowed 4 Divorced Specify the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Frank C. Marano Anna J. Monkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela O. Mattoon / Daughter 8055 Fetlock Court, Ellicott City, Maryland 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 - Other (Specify) Loudon Park Cemetery 1/25/2012 Baltimore, Maryland Signatul of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ UTE disease or condition MINNIN Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in mediate Examiner Dust to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical U/VK/J/QVDivision of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed **Director:** After this certificate I Yes 2 No 1 Yes 21 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No 1 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) Time of 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending ☐ Acciden 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 0051865 20. 2012 57 900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES CURTIS MD

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

Registrar's Signature

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene																		
		= State Registrar Certificate of Death Reg. No. 2012 01470													Ο				
			Registrar	e (First Middle	(ast)			Ce	rtifica	te of D	eath		0.0		lo. 2 U	16	UI	4/	U
П	Physicia Medi		Elizab		,	oh Pe	arre	<u>:</u>					2. Date of De Month	D	1ay 21. 20	Year		of Death	И
jan.	Exami		4a. Facility Name (if						4b. City, Town, or Location of Death						c. County c		8:00	J A	
4			Sympho					Baltimore City											
	Funeral Director	ı	5. Social Security N 212-32-		6. Sex 1 \(\text{M} \) 2 \(\text{J}	7. Age	e (In yrs. Ia 91	ast birthday) Yrs.	Months Days Hours Min (Month Day Vo							9. Birthplace (State or Foreign Country) 1920 Pikesville, Maryl			
			Usual Residence of	Decedent								1	ecenter	10,	1920 [1	·ukes	лце,	Mary.	lan
	ıryland I-f sho ied at	ctor	10a. State Maryland	10b. County Baltin	020			y, Town or Lo								1	0d. Inside		
	he Ma or 28a e notif	ļ <u>ä</u>	10e. Street and Nur		ore .		Ow	ings N		ip Code				100.0	itizen of W	ant Cour		es 2 🔀 N	10
	with t s 23a ust be	Funeral Director	12233 Ga	rrison	Forest	t Road 21117								Stat					
	death items ner m	Fun	11. Marital Status		Arm	Decedent E	dent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-						- Americ	an Indian,					
9000	urs after tural", or al Exami	ted by	1 🌠 Never Marr 3 □ Widowed		ed 1XX	Yes 2 s, Give or Dates.	No			2 X No		, 45/1011	10411, 010.,		Specify:	White, 6			
15-	College (1-4 or 5+) Elementary/Seconday (0-12) College (1-4 or 5+) College (1-4 or 5+) Homemaker											16b.	16b. Kind of Business Industry						
212													wn Ho	mφ					
To see the see that the see tha														JE:					
ryla	Aubrey Pearre Aubrey Pearre Fanny Moncure Lyon															_			
	and 2 sho Health an tem 27 is		Aubrey					1								State, Zip Code) Point, MD 2123			
ore,	of Healt of Healt fitem 2		20a. Method of Disp	osition			20b. P	lace of Dispo	sition (Na	me of	1	anuar			_ocation - C			7 412	.51
Baltimore,	t. Page 1 tment of tant: If it tjury or o		1 🗌 Burial 2 4 🔲 Donation	5 Other (S)	3 Li Removal becify)	from State	Eva	ns Fune	ral' d	apel-E	el Air	2012	y 23,	Fo	rest H	ш,	Maryla	nd	
Aubrey Pearre, IV (Nephew) 1634 Shakespeare Street Apt. 5 Fells Point 20a. Method of Disposition Date												es-Ma	nktan						
			23a. Part 1. Entel	ne disease, or o	complications nly one cause	that caused on each line	the death	. Do not ente	er the mo	de of dying.	, such as ca	ardiac or	respiratory ar	rest,	.21111		Approxim Interval B		-
and c	Medical		Immediate Cause (disease or conditio resulting in death)		_ a	As	Dir	At:	on	00	1e-	in	oni	9			On et and		
-	Examiner		resulting in death)	- 1	D.	o (or as	onsequ	ence of):	2 4	1							<i></i>	1.0	
		iner	Sequentially list con in any, leading to in- cause. Enter Under	nditions,	b	to to for as a	Consequ	anca of,.	601								Jan		\dashv
	executed ian and irial-transit	Examiner	Cause (Disease or i that initiated events	injury	c											\perp		<u>-</u>	
0			resulting in death) L	ast		ue to (or as a	consequ	ence of);											
68760	certificate be nding physici use as the bu	/ledio			d														
39 ×	n certi ending r use a	an/N	IF FEMALE: 23b. Was decedent		23c. If yes	s, outcome o	of pregnar		Ectopic	pregnancy					23d. Date	of delive	ry		
Box .	FFEMALE: 23c. If yes, outcome of pregnancy 1 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 2										Mont	n	Day	Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										use contrib	ute to the	e cause of	death?						
ds,	requires been sig should b	ted t											1 🗆	Yes 2	No 3	☐ Prob	ably 4	Unknow	'n
Comp Coate has													24a. Was auto	psy	pri	or to con	sy finding: npletion of		,
										1 \(\text{Yes}	2 N		th? Yes	2 🗆 No		_			
Vita	ysicial s certi directo	To Be	examiner?	No	Hospital:	1 🗆 Innatia	nt 2 🗆 I	ER/Outpatier	* a 🗆 E	Other	e of Death	,			- 5/au	A	225	fed	-
of	ng Phy ter thi		27. Manner of Death	_	28a.	Date of injury (Month, Day,	/ [:	28b. Time of injury		28c. Injury a work?			e 5 🗌 Resid d. Describe h			Specify	-Acc 3	ly	
ion	ttendii death. tor: Ai the fu	Certificate:	2 Accident 3 Suicide	5 ☐ Pending Investiga 6 ☐ Could n	ation				М	1 🗆 Y	es 2□N	lo							
Sivis	al or A s after i Direc d in by		4 Homicide	determin	28e. F	Place of Injur ouilding, etc.	y - At hor (Specify)	ne, farm, stre	et, factor	y, office		28	If. Location (S City or Tox			or Rural I	Route Nun	nber,	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the carried										use(s) a	nd manner	as stated		annor eta	tod				
only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year,											ted.	iailler sta	leu.						
	1940		· M	And	Tym	, 1/	Le	y u	0 "	Ph.		200	-					2012	2
	log		30. Name and addre	ss of person w	no completed	cause of de	ath (Item)	3a) (Type, P	rint)	11	<u></u>	0-	St. C	0	00	,,,,	1 31) A /	
	Stat	e	31. Date filed (Month	, Day, Year)	0040	32. Registrar	's Signatu		01	14-1	cun	200	01, 6	X.C	KPD.	me	21	20,5	
	Registra			JAN 2 4	2012	Char	a ,	0. A	arte										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 201\(^2\) Jedan Phillips Jr. 0945AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5557 Elderon Avenue Baltimore n/a Social Security Number Sex 1X M 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Min. (M8nth:4P=1994) **Director** 220-41-7155 MD 17 Usual Residence of Decedent 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f 1X□ Yes 2 □ No MDBaltimore n/a 10e. Street and Number 5557 Elderone Avenue 9 10g. Citizen of What Country? pe items 23a Funeral Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Examiner þ Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 African-American 1 ☐ Yes 2 X No Specify: 3 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11th Student High School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lita Stanton Jedan Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5557 Elderone Avenue, Baltimore, MD 21215 Lita Johnson/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 1-28-2012 Baltimore, MD 4 Donation Other (Specify) Metro Crematory of Fun 22. Name and Address of Facility Whie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Osteosarcomo disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or imjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical I or Attending Physician: The law requires that the death certificate beathred eath. Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year signed by the a Id be detached f g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' this certificate 1 Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **N**0 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N Wallest GIVESC Baltimore 900

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month January 22, Year 201 Stephen Perlson 4:36 PM 2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16 Old Court Road #209 Pikesville Baltimore Social Security Numbe UNK 6. Sex 7. Age (In yrs. last birthday) **71 Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. oct, 64 Year 1940 New Jersey **Director** 1 **X** M 2 □ F show 10a. State be filed within 72 hours after death with the Maryland at 10c. City, Town or Location Director 10d. Inside City Limits r 28a-f sh notified a MD Baltimore Pikesville 1 Yes 2 X No 10e, Street and Number 10f. Zip Code r items 23a or iner must be r 10g. Citizen of What Country? Funeral 16 Old Court Road #209 21208 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. er than "natural", or ite Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Salesman Automobile r traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Inportant; If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ David Perlson Evelyn Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Perlson-Hernandez /Daughter 1 Surrey Lane East Windsor, NJ 08520 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan 27 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Riverside Cemetery Saddle Brook, NJ 2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Alternatives MO1585 Rebecco 8717 Green Pastures Drive Towson Maryland 21286 Remon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Atheroselerote disease or condition resulting in death) Carriovasiular Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown 2 No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardion yo pathy 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy Hypertension (4ronic distructure Pylmonory Disease 24b. Were autopsy findings available prior to completion of cause of death? s certificate has build be continued in the continued in performed? 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🗌 Yes 2 🗀 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number Haren P. Balitt, M.D. D0058676 Januar 23, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 54/te 301 Karen L. Babite your dd court Nocal Beltmore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

			1 - For State Registrar	State of	of Mary	land / De	partmen e <i>rtificat</i> e			and Me	ental Hy	giene Reg. No	21	12	0147	
			1. Decedent's Name (First, Middle	e, Last)							2. Date of De		211	Year	3. Time of Death	
	Physici /Medi		JAMES	PIER		N					JAN	AN 17 2012			3:01 AM	
	Examir		4a. Facility Name (If not institution Johns Hopkins Ba			nter		4b. City, Town, or Location of Death Baltimore						4c. County of Death		
Ī	Funeral Director	0	5. Social Security Number 217–14–7282	6. Sex 1 XM 2 ☐ F		n yrs. last birthda			If Under Hours	Min,	8. Date of Bi (Month, Da Jan.	av. Year)	22	Count	lace (State or Foreign ry) vland	
			Usual Residence of Decedent							1	Jan.	2917	/22			
	anylan show	<u>_</u>	10a. State 10b. County	,	10	Dc. City, Town or	Location							1	0d. Inside City Limits 1 ☐ Yes 2x No	
	he Ma 28a-f otliflec	ecto	MD Balti	more			1]	Dunda1					
	with the sa or	Funeral Director	10e. Street and Number 7801 Peninsul	a Express	way	Apt. 32	3 10f. Zip-		222		{	_	itizen of W nited		-	
	death ms 2.	nera	11. Marital Status	12. Was Dec		r in U.S. 1	3. Was Deced If Yes, spec			igin? (Spec	ify Yes or No		14. Race	- America	an Indian,	
920	urs after al", or Ite	ð	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	I It Yes (iii)	e ² TNo		If Yes, spec		n, Mexicai Specify.					Black, White, etc. ec <i>ily:</i> White		
5-0	72 ho natur iicai i	Completed		nt's Education est grade completed)		ı (Gi	cedent's Usua ve kind of wor	k done d	lurina mo:	st of workin	a	16b. l	Kind of Bu	isiness/Ind	dustry	
121	vithin ne. han "	Id II	Elementary/Secondary (0-12)	College (1	-4 or 5+)		. DO NOT us					_D .	. 1	0.		
2	filed v Hygie ther t	The state of the s												-	npany	
lan	ld be ental ked o c eve													1tz		
ary	shou and M s mar umati	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Mr. Douglas G. Piereman (Son) 9 Broad Leaf Court Baltimore, Maryla														
Σ	and 2 salth a n 27 ls		Mr. Douglas G.	Piereman	(Sor	1) 9	Broad								d 21234	
more	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			20b. Place of Dis cemetery, c Hillto	rematory or of	her plac		. 1/18			ocation -	•	_{wn, State} ry1and	
Salti	permit. Departr Importa any Inju		21. Signature of Funeral Service	Licensee	_		22. Name an Duda-	Addres	s of Facili Fun	eral 1	Home o	f Du	ında1	k, I1	nc.	
ä	죠▷ 늘 ▩ 이		23a. Part 1. Enter the disease, or	7 //es	accord the		7922	Vise	Ave	. Dunc	dalk,	Mary	1and	21:	222	
			shock, or heart failure. List Immediate Cause (Final	only one cause on e	ach line.		enter the mod	or ayırı	g, such as	s cardiac or	respiratory	arrest,		ļ	Approximate Interval Between Onset and Death	
1	Physician /Medical		disease or condition resulting in death)	aS	EPS	onsequence of):								1	2 DAYS	
T. A.	Examiner					MON!	4								2 DAYS	
		ner	Sequentially list conditions, if any, leading to immediate	D		onsequence of):	1								LVAIS	
	cuted Id Iransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):														
o,	ate be executed hysician and the burial-transit	a E	resulting in death) Last Due to (or as a consequence of):													
8760,	cate be executed oblysician and the burial-transit	dical		d										-		
So was decodent pregnant in the past 12 months? 1													23d. Date of delivery Month Day Year			
	res that the de igned by the a' I be detached i	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗆 Unkr		e of death	5 ☐ Other (spe	:City)								
, P.O.	that t ed by deta		Part II. Other significant condition	ons contributing to c	eath but n	ot resulting in the	e underlying	ause giv	en in Parl	t I.	23e. Did	tobacco	use contr	ribute to th	ne cause of death?	
rds	quires n sign uld be	q pa	MYELOPRO	LIFERA	TIV	EI	SISOR	DE	R		1 🗆	Yes 2	2 🗌 No	3 🗌 Prob	abiy 4 🖫 Unknown	
Division of Vital Records,	The law require ate has been sig page 2 should l	Completed by										psy ormed?	, F	orior to co death?	psy findings available mpletion of cause of	
tal			25. Was case referred to medical						26. Place	e of Death /	1 ☐ Yes Check only o	2 ☑N	lo 1	Yes	2 No	
Ţ	Physician: this certifica ral director,	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient	2 ER/Outpati	ent 3 🗆 DO	Othe	۳.		e 5 Resi		6 ☐ Othe	er (Specify)	
0 1	ng Phy ter this	no.	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date (Mon	of Injury h, Day Yea	28b. Time		Bc. Injury Work	at		Bd. Describe					
isio	Attending ar death. ector: After by the fune	cati	2 Accident investi	gation	of injury	At home form	M M		res 2□		Dr. I	(041			I Davida Alembra	
Ω	tal or Attending Physics after death. al Director: After this ed in by the funeral d	Certification:	4 ☐ Homicide determ	ined build	ng, etc. (S						City or To	wn, State	e)		Il Route Number,	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by t	Medical	29a. Certifier 1 ☐ Certifyir (check only one)	ng Physician: To the Examiner: On the b and mar	best of m asis of exa ner stated	amination and/or	ath occurred investigation,	at the tin in my o	ne, date ai pinion, de	nd place, a ath occurre	nd due to the	e cause(e, date ar	s) and ma nd place,	inner as s and due t	tated. o the cause(s)	
	vithi To th	Ž	29b. Signature and title of certifie	r 1—		1 7			number	00			ate signed			
		}	30. Name and address of person	who completed care		1.D. h (Item 23a) (Tvp			3 C			J 75	10	ΙΤ,	2012	
1	101		NANDINI	YAD		(non zoa, (1yp	o, 1 1019		49	940 Ea	stern A	venu	e, Bal	ltimor	e, MD, 2122	
	Sta		31. Date filed (Month, Day, Year)	32. R	egistrar's	Signature										
D	Registr MH 17 Rev 1/20		JAN 2 4 2012	General	1.	park										

DHMH 17 Rev 1/2001 11595

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 21 □2012 Mildred Elizabeth Peacock Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Months Days Hours February 1: 1910 Mary land 101 **Director** 215-05-9299 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho may injury or other tranmatic event, the Medical Examiner must be notified at any injury or other tranmatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 613 N. Paca Street USA 21201 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 🖾 Yes 2 🗌 No WWII Black, White, etc. White by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Social Security Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel M. Peacock Mary E. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Don Peacock/ Nephew 613 N. Paca Street Baltimore MD 21201 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 1/27/12 Baltimore MD Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc 5305 Harford Road F Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ons I in Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** So continue list a militi as Be Completed by Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending proposed with the standard proposed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and the Funeral director, page 2 should be detached for use as the burial-transit. that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Urknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 ျ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE 2300 DULANEY PREISVALLEY ROAD TIMONIUM. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

2012

JANUARY 21,

MILDRED PEACOCK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month - 28ay 12 10:517 a M Poldmae Douglas Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore 1301 W. Northern Parkway 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 06-06-1932 Estonia 220-30-1229 79 Director 1 1 X M 2 □ F Usual Residence of Deced 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? by Funeral USA 21209 1301 W. Northern Parkway permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc 1 Yes 2 If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Korea 3 Divorced 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Business 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ Renate Virro Voldemar Poldmae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |Mrs. Maret M. Poldmae - Wife 1301 W. Northern Parkway Baltimore, Maryland 21209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Hilltop Service Corporation 01-24-2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Service Licensee Signatu 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ stage disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Litter Unidentifying Cause (Disease or injury Due to (or as a consequence of): nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death P.O. signed by d be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 \square Yes 2 \nearrow No 3 \square Probably 4 \square Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Z Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10064261 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lunden 31. Date filed (*Month, Day, Year*)

JAN 2 4 2012 32. Registrar's Sgnature State Registrar

Oam

V

9

RIOR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day (2 Year Month (7 6.50 PM John Benjamin Ratlief Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 234-56-5051 **Director** 1 **X** M 2 □ F 75 08/21/1936 West Virginia Usual Residence of Decedent 28a-f show 10a. State with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Tucker 1 🗆 Yes 2 😾 No Davis 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 154 Hikers Challenge Road U.S.A. 26260 Page 1 and 2 should be filed within 72 hours after death i "natural", or iterr edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2X Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha Manager Sears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Important: If item 27 is marke any injury or other traumatic once. Walter Ratlief Edna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carol Ratlief / Wife 154 Hikers Challenge Road Davis, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 01/20/2012 Glen Burnie, MD Signature of Funeral Service Lic 22. Name and Address of Facility 1 2nd Avenue SW MO1479 Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ store disease or condition resulting in death) mesosta Medical Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 K Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has it death? To the Hospital or Attanding Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 1 ☐ Yes 2 🗷 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) Other (Specify) 1 ☐ Yes 2 ☒ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hospilanst, mo D.Walum D71488 1117/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neda Warmen 3-1 Hospital) 20 (then Burne im) Meda notame Dave. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month W. Reichenbach Clair 3:00 P^M 18 2012 Medical Jan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 29 Oldfield Court Mi<u>ddle River</u> <u>Baltimore</u> 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours Director 205-16-2652 1 X M 2 🗆 F 82 Aug. 19, 1929 Pennyslvania 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland be notified at Director 28a-f MD Baltimore Middle River 1 Tes 2 No ō 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a oner must be Funeral 29 Oldfield Court 21220 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter 14. Race - American Indian Armed Forces' Black, White, etc. þ 1 Never Married 2 Married X Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Divorced Year or Dates White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. BGE 8 Years Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental Fitem 27 is marked of other traumatic even ၉ Ella Mae Schock Maurice Reichenbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary T. Reichenbach Department of Health Important: If item 27 any injury or other tr Middle River, MD <u>29 Oldfield Court</u> 21220 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Holly Hill Mem. Gdns. 1/23/2012 Middle River, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Services Duda-Ruck Funeral Home of Dundalk, Inc. Micha Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atte in the past 12 months? Month Year Pregnant at time of death Day Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate has been significate has been significated and funeral director, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 246. Were autopsy findings available prior to completion of cause of death? 24a Was an performed completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျ 1 Tyes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA Mann of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No after death Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Certifying Nurse Practition 29b. Signature and title 29d. Date signed (Month, pay, Year)

State Registrar 31. Date filed (Month, Day,

Year)

death (Item 23a) (Type, Pring

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dan Smith State of Maryland / Department of Health and Mental Hygiene 2012 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death 3 Time of Death Month Medical Examiner 0810 hrs Dan R. Smith January 21, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 17737 Backbone Road Parkton **Baltimore County** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Min Director 291-05-6037 June 15, 1918 93 Country) Chio 1 XM 2 F Usual Residence of Decedent III 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Baltimore Maryland Parkton 1 Yes 2 X No 1 23a or 28a-f show protified at once. or 28a-f show with the Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 17737 Backbone Road 21120 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, is marked other than "natural", or items atle event, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. I and 2 should be filed within 72 hours after death 1 Never Married 2 XXMarried Specify: White If Yes, Give Year 4 Divorced 1 Yes 2 X No specify: ρ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12 2 Baltimore County Engineer Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Smith Nell Dorbert Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Smith (Spouse) 17737 Backbone Road Parkton, Maryland 21120 If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, Pages 1 ment of 1 1 Burial 2 Cremation 3 Removal from State Mt Carmel United Methodist January 27, 2012 Monkton, Maryland 4 Donation 5 Other Specify Church Cemetery Signature of Funeral Service Licenses Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Monkton
16924 York Road Monkton, Maryland 21111 23a. Part I. E the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** bnly one cause on each line Between Onset and /Medical Death a Contact Gunshot Wound of Head **Examiner** Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury trial miniated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the a signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been a 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 V No 2 No Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes After 28a. Date of Injury FOUND: 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot self 1 Natural FOUND: Director: 5 Pending 1 Yes 2 ✔ No death. Jan 21, 2012 0745 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 🗹 Suicide Could not be or Town, State) 17737 Backbone Road, Parkton, MD 24 hours a determined (Specify) Field 4 ___ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME January 22, 2012 LOIV 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State racke Registra

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Robert Dana Sterling, Jr. 2012 January 12:05 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Seasons Hospice @ Northwest Hospital Baltimore Randallstown Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 215-84-4379 1 🗙 M 2 🗆 F 50 May 5, 1961 Virginia Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2004 Girard Avenue 21211 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Completed Specify: White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Local Hauling Be permit. Page 1 and 2 should be filed Department of Heath and Mental Hy, Important; If item 27 is marked oth any injury or other traumatic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Robert Dana Sterling, Sr. Sheila Jacqueline Jeffords 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Euva D. Sterling, 1224 Baillies Bluff Road sister Holiday, FL 34691 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 01/23/12 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final AICHOMA Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of, Examir trar Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ō in the past 12 months? Month Pregnant at time of death Day Year 2 No the 9 Unknown g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes Probably 4 ☐ Unknown cate has been signated bage 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence & Other Spe 2/ No Wisnece 1 🗌 Yes မ this 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural 5 Pending nours after death.

neral Director: Aff

filled in by the fu 2 \square No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature/a 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23%) (Type, Print) 2838 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Walter Eugene Snyder 2012 9:14PM January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A 524 N. Charles Street Apt. 1700 Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) Funeral Hours 162-26-4211 Director 1 XM 2 □ F 78 Yrs. Feb 10, 1933 Pennsylvania Usual Residence of Decedent 28a-f show 10h County at 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 X Yes 2 ☐ No Marvland N/A Baltimore 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 524 N. Charles Street Apt-1700 21201 **USA** death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc o 1 X Never Married 2 Married þ 1 Yes 2 No 1955 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: White Completed 1958 Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Purchasing State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) : Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o Mental | marked ပ Eleanor P. McClane Lawrence M. Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray M. Snyder, Brother 1300 Hickory Springs Circle Catonsville, MD 21228 20a. Method of Disposition
1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. 20c. Location - City or Town, State Date 9 Important: If any injury or 12/24/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Remarkant Address of Facility Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Lom 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ atheroscherosis Coronary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 4 cas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury attending physician and I for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 1 Yes 2 g Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy perform 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer 1 Natural 5 Pending work 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practifying: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 30. Name and address of person who completed cause of death (Item 23a) (Type, Print vite 255. Lutherville, 40 21098 Falls Rel 10753 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10e, 19b per fh g923 1-26-12 yt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 21, 2012 CHARLES THOMAS SHORTALL 12:35A M JR Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 1**XX**M 2 □ F 05/02/1935 Marviand 214-32-6510 76 Director Usual Residence of Decedent 28a-f shov items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2**X** No Maryland Baltimore Lutherville 8209 Street and Number 10f. Zip Code 10g, Citizen of What Country? 8902 Tally Ho Road 21093 USA ı "natural", or item edical Examiner π 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

11 Yes 2

If Yes, Give Black, White, etc. Aq 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Completed 3 Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Veterinarian Animal Hospital other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ္ Charles Thomas Shortall Sr Agnes Golt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3902 Tally Ho Road Lutherville, Maryland 21093 Diane Edgell Shortall Wife 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

GreenMount Crematory

01/28/2012 1 Burial 2XX Cremation 3 Removal from State Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Funeral Service Licenses 22. Name and Address of FathPtchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, r complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cycles on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ear Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 No page 2 \square No 1 Tes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work?
1 Yes 2 No s after death.
I Director: Af 2 Acciden 3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29c. License number 30. Name and address of person who completed cause of death (It m 23a) (Type, Print) 10 6701 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death t Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Patsy Haley Stann Jan. 21 12:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3421 Raymond Street Chevy Chase Montgomery Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 409-78-4648 1 M 2 X F 67 June 29,1944 North Carolina at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f si notified MD Montgomery Chevy Chase 1 Yes 2X No 10e. Street and Number ō 10f, Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 3421 Raymond Street 20815 IISA ral", or items ? Examiner mus death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black White etc Completed by 1 Never Married 2 X Married 2 X No Maryland 21215-0036 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural". 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Law Librarian Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental | marked o and of Health and titem 27 is marke. ျှ Curtis Brabson Haley, Jr. Patti Davenport 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Jeffrey Stann/husband 3421 Raymond Street Chevy Chase, MD 20815 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 😾 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 1/25/12 Woodbine, MD Name and Address of Facility
Going Home Cremation Service

Reverly L. Heckrotte, P.A. 21. Signatur of Funeral Societe Licenses TRM01251 P.O Box 784 Clarksville. MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
1/2 yrs Immediate Cause (Final Prymician/ Non Small Cell Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No 3 Ectopic pregnancy 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law page 2 s certificate has autopsy performed' death? Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: ျှ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Director: After 1x Natural 5 Pending death. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, within 24 hours after To the Funeral Direc determined City or Town, State) To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nursu Prontificaers: the least of my knowledge death occurred at the time, date and place, and oue to the cause(s) and manner stated. 29a. Certifier

30 V

State Registrar (Check

29b. Signature and title of certifier

when

Frederick G. Barr, MD JAN 2 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5454 Wisconsin Ave, #1300 Chevy Chase, MD 20815

om MX

DHMH 17 Rev 06-2011

29c. License number

D22775

29d. Date signed (Month, Day, Year)

Jan. 24, 2012

SAMAD Pt (CAOUN) AS ISHMAIL Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For amen	Please	Type or Pri amend 201 State of M Ob per fh	int in	Black	Indeli 923 parime	ble Inl	c. Ensu l 2 lealth a	ure A and N	II Copie Iental Hy	s Ar	e Legi e	ble.		
					B 723	1-21	ertifica	te of L	Death			Reg. N	· 20	12	01183	
Physicia Medio		1. Decedent's Name	AIL 3	SAMAD							2. Date of De Month	eath	ay 2	Year 012	3. Time of Death	
Examin	er	SINAI HOSPITAL of BALTIMORE CAY														
Funeral Director		212-42-8 Usual Residence of	3355 1	M 2 □ F	e (in yrs. ii 6		Months		Hours	Min.	8. Date of Bi (Month, Di 4/15	ay, Year)		9. Birthpli Countr	ace (State or Foreign y)	
yland •f shov ed at	ctor	10a. State	10b. County			y, Town or							·	10	d. Inside City Limits	
ne Mar or 28a- notifi	Director	MD 10e. Street and Nun	na		Ва	ltim		ip Code				40.0	dal		1X Yes 2 □ No	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	4153 Fa	airview			- I.	2	1216				Ü	itizen of W			
fter dea	by	11. Marital Status 1 ☐ Never Marri	ed 2 Married	12. Was Decedent I Armed Forces? 1 X Yes 2		S. 1	If Yes, sp	ecify Cubar	n, Mexican,	in? (Spe Puerto	cify Yes or No Rican, etc.)			- America , White, et		
ours at atural"	eted	3 Widowed	4 Divorced	If Yes, Give Year or Dates.		10- 0-		2 🔀 No					Specify:	Bla		
in 72 h	Completed	(Spe-	cify only highest gra		5+1	(Gi	cedent's Us ve kind of w . DO NOT u	ork done d		of worki	ng		Kind of Bus		•	
d withi tygiene ther th nt, the	0	12th		odlogo (1 4 di c		Del	iver	y ma				Baltimore Sun				
l be file fental H rked of tic ever	To B	17. Father's Name (First, Middle, Last) Robert Smallwood 19a. Informant's Name/Relationship (Type, Print) Spring by Samadawife 18. Mother's Name (First, Middle, Maiden Surname) Fannie Tubman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 415.3 Fairview Ave. Baltimore, Mi														
should h and M 7 is ma traumal		19a. Informant's Na	me/Relationship (7)	ype, Print)		19b. Ma	ailing Addre	ss (Street a	nd Number	or Rura	Route Number	er, City o	r Town, Sta	ate, Zip Co M.D	21216	
t and 2 f Healti item 2 other t		Saidah 20a. Method of Disp		ife	20b. P		53 Fa		ew A	21r			ocation - 0			
Page treet or tant: If tant: If jury or			Cremation 3 5 Other (Specif	Removal from State	0	emetery, c	rematory or emori	other place	· .	$1/\frac{1}{2}$	712 1/202 :	1	altin	•		
permit Depart Impor any in		21. Signature of Fur	neral Service Licens	see Andro	1		22. Name a		s of Facility	t.	4300 (Balti	Waba	sh A	ven	ue 1215	
		23a. Part 1. Enter the shock, or hear	ne disease, or comp	plications that caused	the death	n. Do not e							-/ 111		Approximate	
Physician Medical		Immediate Cause (I disease or condition resulting in death)	Final	a. CACD Due to (or as		RES	PIRA	TOR	Y	AR	2RES	į (T			Interval Between Onset and Death	
Examiner		,		bb.						4-	0,216	000	111143	-A.		
ed sit	Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i	mediate lying	Due to (or as	a consequ	ence of):						11.10				
executed ian and urial-transit		that initiated events resulting in death) L		C. Due to (or as	a consequ	ence of):		-								
cate be physicia the bu	edica		-	d										_		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b.	~	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)										23d. Date Mont		y Day Year		
hat the ed by th detach	y Phy	9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did t	obacco	use contrib	ute to the	cause of death?	
quires t	ted by										1 🗆	Yes 2	□ No 3	B ☐ Proba	ably 4 Unknown	
The law reate has be bage 2 sho	Completed										24a. Was auto perfe 1 \sum Yes	psy ormed?	pri de		y findings available pletion of cause of	
cian: Tertifica	Be	25. Was case referre examiner?		Hospital:					ce of Death	(Check		_	0	163	2110	
Physi r this c eral dir	욘	1 Yes 2 2 27. Manner of Death	No	1 Inpatie		ER/Outpat 28b. Time	ient 3 🗆 D	Other 28c. Injury	4 ∐ Nur		me 5 Resi					
ending eath. or: Afte the fun	Certificate:	1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending Investigation	(Month, Day	r, Year)	injury		work?	res 2 🗆 N		ou. Describe	low Injui	y occurred			
tal or Att rs after d al Direct led in by		4 ☐ Homicide	6 U Could not be determined	28e. Place of Inju building, etc	iry - At hor :. (Specify)	me, farm, s	street, facto	ry, office		2	28f. Location (City or Tov			or Rural R	oute Number,	
n 24 hou n 24 hou le Funer	Medical	(Check 2	Medical Exami	sician: To the best of ner: On the basis of ex se Practitioner: To the	kamination	and/or inv	estigation, in	my opinior	death occ	urred at	the time date a	and place	and due t	o the caus	e(s) and manner stated	
To th Comp		29b. Signature and ti			^			c. License					ite signed (-	
	-	P 4	luly	er m	シ	00-1-7	7) 00	69.	59	4		120	>12	610	
		$D_{\mathcal{Q}}$. $W_{\mathcal{W}}$	ss of person who c	ompleted cause of de	eath (Item	23a) (Type	MoRS	EN/	7710m	AL	PIKE.	Ca	Ton .	SVIL	012 MD LE, 7/228	
State Registra		31. Date filed (Month	4 2012	32. Registra	s Signat	arks.	1			· · ·				14.16	10,50	
legistia																

			For State Registrar	Pleas am	e Type or amend State o end #1 P	Print in 1,23a Marylar erPhy	Black Ir pt II 1924 2/ Ce/	ndelible per phy artment of 07/201 tificate of	Ink. 30 2 JE 2 JE	Ensu alth a ath	ure Al DVR and M	II Copie 2923 ental Hy	es Ara 1-24 giena Reg. N	e Legible 4-12 sm	». 2 011.91	
	Physicia		1. Decedent's Name	e (First, Middle, L	^{ast)} Elean llou Elea	or Chal	llou ak	a				2. Date of D	eath	7,2012 ^{ear}	3. Time of Death 9:15P M	
e e	Medic Examin		4a. Facility Name (if	not institution, gi		iber)	-	4b. City, Tow	n, or Lo		f Death		<u> </u>	c. County of Dea		
	Funeral Director		5. Social Security N 127-07-02	If Under 1 Y	ear If	Under 2 Hours	24 Hrs. Min.	8. Date of Bi		9. Bro	irthplace (State or Foreign ountry) OKLYn NY					
	and show Lat	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location												10d. Inside City Limits	
	ne Maryla or 28a-f	Director	Md. Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of Wha										itizen of What C	1 Yes 2 No		
	th with the ms 23a community be	neral	301 West					2	1014				<u> </u>	itizen of What C USA		
9800	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Marr 3 Widowed	4 Divorced	Armed For 1 ☐ Yes If Yes, Give Year or Da	2 X No e		Vas Decedent f Yes, specify (in? (Spec , Puerto R	ify Yes or No- lican, etc.)	-	14. Race - American Indian, Black, White, etc. Specify: White		
Maryland 21215-0036	iled within 72 ho I Hygiene. other than "nai rent, the Medica	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)									(1	.Kind of Business Industry (Minicipality) wn of Carmel			
land	d be filed Jental Hy srked oth	To Be	17. Father's Name ((First, Middle argan	, Maiden	Surname)		
	ind 2 should be file lealth and Mental F m 27 is marked o her traumatic even		19a. Informant's Name/Relationship (Type, Print) Colleen C. Allen DTR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 1911 Munsey Dr. Forest Hill, Md. 2											or Town, State, Z Md • 21	ip Code) 050	
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra			☐ Cremation 3 5 ☐ Other (Spe		State C	Place of Disposemetery, crem ion Val	atory or other 1ev Ce	place) m .		-14-2		M	ahopac. eral Ho		
Ä	an Jed		23a. Part 1. Enter the	un G	mplications that co	LLL aused the deat	6	510 W.	MacE	Phai	1 Roa	ad B	el A	ir, Md.	21014	
0	Medical Examiner	8. 1	shock, or hear Immediate Cause (I disease or conditio resulting in death)	t failure. List only Final	one cause on eac	or as a consequ	Je 1)unie	~	ucii as c	artiac or	respiratory at			Approximate Interval Between Onset and Death	
1		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inigny that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d													
W.	izi e	ical Exar														
. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physic ated filled in by the funeral director, page 2 should be detached for use as the but the funeral director.		IF FEMALE: 23b. Was decedent pregnant 1											elivery Day Year		
Division of Vital Records, P.O.	quires that the sen signed by ould be detact	ted by Pr											^			
Recor	The law re rate has be page 2 sh	Comple												prior to death?	utopsy findings available completion of cause of as 2 No	
/ital	ding Physician: The le .h. After this certificate he funeral director, page	Be	25. Was case referre examiner?		Hospital:				Othor		(Check o					
of \	ig Phy ter this neral d	te: To	27. Manner of Death		28a. Date o	npatient 2 of injury on, Day, Year)	28b. Time of injury	28c. I	njury at	1 □ Nur		ie 5 L Resi 3d. Describe I		Other (Spen	cify)	
ivision	I or Attendir after death. Director: Af d in by the fu	Certificate:	Natural 2 Accident 3 Suicide 4 Homicide	5 Pending Investigation 6 Could not determined	be 28e. Place of	of Injury - At ho g, etc. (Specify,	me, farm, stre	M 1		2 🗆 1	-	3f. Location (S City or Tov			ural Route Number,	
The part of the pa											and due to the	cause(s) and manner stated				
4	To the within 2 Comple		29b. Signature and t				3	29c. Lice	ense nur				29d. Da	ite signed (Mont		
			30. Name and addre					int)				,	1-7	NACY	1)	
В	State Registra	e r	31. Date filed (Month	AN 2 4 2	012 32 A	gistrar's Signat	J. La	W.	ALL	, rw ,	2101	4				

Mchallou, Eleanor

January 7,

2012

9:15

pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month 25 PM Januari Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HMIRLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Year
AUG 25), 5. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F Yrs. Director Usual Residence of Decedent show 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 🗓 Yes 2 🗌 No Hamou 10e Street and Number ò 10f, Zip Code 10g. Citizen of What Country? Funeral 23a 219 L pernit. Page 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygiene. Important: If item 27 is marked other than \(\) no other trees. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Nes 2 If Yes, Give Year or Dates. 2 No 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: Army 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) remar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 omer Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address_(Street and Number or Rural Route Number, City or Town, State, Zip Code) 622 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 26/2012 4 Donation 5 Other (Specify) Sign ur of Funeral Service 22. Name and Address of Facility 4600 Heia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ons t and Deat Immediate Cause (Final Physician/ disease or condition resulting in death) -Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burial-t attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown P.O. I signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy performed? Yes 2 N death? this certificate 2 🗌 No Yes I ☐ Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 0 No Other: 1 🗌 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending
Investigation Natural Natural work death. Accident 1 🗌 Yes 2 🗆 No after death

Director: A

d in by the f Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 10043375 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SUITE 203

SALTIHOKE,

SKITH

2835

METUYET

4

2

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2012 Eldon Lewis Stearn 7:10 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3622 Old Level Road Harford Havre de Grace Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Feb. 13, 1926 7. Age (In yrs. last birthday) **Funeral** g. Birthplace (State or Foreign Maryland 1 ₺ M 2 🗆 F Hours Min. Director 216-20-8891 85 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Havre de Grace 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 3622 Old Level Road 21078 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black. White, etc. Completed by 1 Never Married 2 Married 1 XYes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) filed within Hygiene. the 11 Weapons Repair Foreman U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Leonard Winfield Stearn Sr. Annie May Hughes permit, Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum: once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Stearn / Wife 3622 Old Level Road, Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gardens 1-24-12 Aberdeen, Maryland Signatur 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 Part 1. Enter the disease, or comications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final Physician/ MULTIPLE MYRICONA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year ☐ Pregnant at time of death ☐ Unknown ate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 **2** No Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) SIN JANUARY 20, 2012 25782004 PITYSJCEAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHECEP ATPUMIN , 500 UPDER CH35 APPENDE DROVE, BRLAZE ND 21014 MAY 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Arthur L. Southard, Jr. 2012 12:48 P.™ Medical January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arden Courts Assisted Living Baltimore Towson 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 93 Days Hours 213-01-3881 Month, Day, Year)
November 13,1918 Mary Land **Director** Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Timonium Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 21093 Funeral 3 Elphin Court Apt. 102 of America death \ 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 X Yes 2 Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: white If Yes, Give 3[™]Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within the and Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Assistant State Comptroller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur L. Southard, Sr. Ada Dailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Flohin Court Apt. 102 Timonium, Maryland 21093 19a. Informant's Name/Relationship (Type, Print) . Page 1 and 2 sl tment of Health a tant: If item 27 is 3 Elphin Court Apt. 102 Ruth Anne Halada/ companion 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite Date 20c. Location - City or Town, State cametery, cramatery or other place) 1 X Burial 2 Cremation 3 Removal from State January 28, 2012 4 Donation 5 Other (Specify) Timonium, Maryland Menofial Cardens 21. Signature of Jun Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. W-2325 York Road Timonium, Maryland 21093 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the Attention of the Funeral Director. burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as t IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Day Pregnant at time of death Month Year 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital 잍 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Gertifying Physician. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 29b. Signature and title of Atifier cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 30. Name and add

31. Date filed (Month, Day,

Year)

Bone

Degistrar's Signature

6701 N. Charles St.

Balto, Und 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anna C. Soustek Month Jan Ye2*01 Day 19 11:30PM Medical 4a. Facility Name (if not institution, give street and number)
Somerford Place **Examiner** 4b. City, Town, or Location of Death Columbia County of Death Howard If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** 215-07-7986 Days Hours (Month, Day, Year) **Director** 1 □ M 2 😾 F 94 8/19/1917 Maryland Usual Residence of Decedent shov 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2 X No the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8220 Snowden River Parkway Funeral 21045 USA ral", or items 2 Examiner mus death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or ☐ Yes 2x No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Midowed 4 ☐ Divorced Completed Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Defense other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) John Yelinek Catherine Braumbart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda A. Pace -Daughter 5976 Elk Forest Ct., Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 /23/2012 Glen Burnie, MD Glen Haven Memorial 21. Signature of Eureral Service License 22. Name and Address of Facility Ambrose Funeral Home 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death ?hysician/ Alzheimers Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami -trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 9 Unknown 9 Unknown ò signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law certificate has autopsy page performed?

1 Yes 2 No 1 Yes 2 YNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2**XX**No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours atter usau..

To the Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending work' 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number mD D56531 Jan 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, 8600 Snowden River Pkwy #301, Columbia, MD 21045

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 4 2012

forus

32. Registrar's Signature

Privacion Medical Scanner Privacion Description and Privacion of Description Privacion D				Please Type or Pr amend_item, 3	int in Black Indelible In Jaryland / Department of	k. Ensure All	Copies Are Legi	ble.					
Privated Medical Females Agreement of Control				1 _ State			2.0	2012 011.00					
Specific Spe				1. Decedent's Name (First, Middle, Last) Arthur Turner,	Tr	2.	Date of Death Month 19 Day 201	3. Time of Death 6:30 A M					
Discretion Discretion Disc		Examir	er	Holy Cross Hospita	Silve	r Spring	4c/County c						
The state of the s	H			250-32-9938 18M2 0 F	ge (In yrs. last birthday) Yrs. If Under 1 Year Months Days	0.		9. Birthplace (State or Foreign Country)					
Specific Specific		Maryland 28a-f show otified at	irector	10a. State 18b. County	10c. City, Town or Location Hyat-sville	-		10d. Inside City Limits 1 ☐ Yes 2 ☐ No					
Specific Specific		with the s 23a or ust be n	eral D			782	10g. Citizen of W	hat Country?					
Specific Specific	980	rs after death ıral", or items Examiner m	Ş	1 Never Married 2 Married Armed Forces? 1 Yes 2 If Yes, Give	? If Yes, specify Cub.	an, Mexican, Puerto Rica	an, etc.) Black						
Specific Specific	21215-0	vithin 72 hou jiene. er than "natu the Medical		(Specify only highest grade completed)	(Give kind of work done life. DO NOT use retired)	pation during most of working -	16b. Kind of Bus	siness Industry					
1938 Informate's Name/Relationship (Type, Fire Daughter) 1940 Marilene M. Turnex 1950 Place of Disposition 1950 Place of Dispo		d be filed v Aental Hyg irked othe tic event,				18. Mother's Name (Fin	/ \						
Total 2 Cremation 3 Removal from State 20 Commetor		2 shou th and the mid 7 is m		19a Informant's Name/Relationship (Type, Printings	1 21100 1	and Number or Rural Ro	حالت مال	ate, Zip Code) MD 20782					
23a. Part 1. Entitude disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Seese or condition resulting in death) Sequentially list conditions, if any, leading to immodiate cause (Disease or impury that imitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate interval Between Onset and Death Science of the cause of the c	more	r pr		1 Lourial 2 Cremation 3 Removal from State	e cemetery, crematory or other place	Date 1/26/	200 Location - C	City or Town, State					
Sequentially list conditions, if any, leading to a mesolate cause. Enter Underlying Cause (Disease or injuny that initiated events resulting in death) Sequentially list conditions, if any, leading to a mesolate cause. Enter Underlying Cause (Disease or injuny that initiated events resulting in death) Last Due to (or as a consequence of): Lue to (or as a consequence of): Due to (or as a consequence of): Lue to (or as a consequence of): Due to (or as a consequence of): Lue to (or as a consequence of): Due to (or as a consequence of): Lue to (or as a consequence of): Lue to (or as a consequence of): Due to (or as a consequence of): Lue	Balt	permit. Departr Importa any inji	1 2	21. Signature of Funeral Service Licenses	22 Vace and Affider	ss Cacilloreer	Pika (71)	Services					
Medical Examiner Nedical Examiner Sequentially list conditions, if any, leading to miniodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a co		التدعين	0 2	shock, or heart failure. List only one cause on each line	d the death. Do not enter the mode of dyine.	g, such as cardiac or res	spiratory arrest,	Interval Between					
Sequentially list of ministrated sevents in any, leading to immissionate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		Medical		resulting in death)	a consquence of)	~~~		2 mes					
O. 680 Source of the contribut		ted nsit		15 years									
TEFEMALE: 23c. If ves, outcome of pregnancy in the past 12 months? 1 Live Birth 2 Fetal death in the past 12 months? 1 Ves 2 No 3 Probably 4 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Conscriptive heart factors Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Conscriptive heart factors 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manney of Death 28a. Date of injury (Month Day Year) (Month Day Year) 26b. Place of Death (Check only one) 27. Manney of Death 28d. Describe how injury occurred	09	te be execu hysician and he burial-tra	<u></u>	resulting in death) Last Due to (or as				1					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Death of Construction of Construction of Course of Construction of Course of Construction of Course of Construction of Course of Construction of Course of Construction of Course of Construction of Course of	. Box 687	ne death certifica y the attending p ched for use as t	nysician/Me	23b. Was decedent pregnant in the past 12 months? 1 \(\text{ Yes} \) 2 \(\text{ No} \) 4 \(\text{ Pregnant a} \)	2 ☐ Fetal death 3 ☐ Ectopic pregnand at time of death 5 ☐ Other (specify) _	ey							
TENDED TO SET THE LOCATION OF THE PROPERTY OF	s, P.O	res that the signed by the detail	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to										
TO TO TO TO TO TO TO TO TO TO TO TO TO T	cord	aw requi as been 2 should	pleted	Congestive heart failure			24a. Was an 24b. We	ere autopsy findings available					
Comparison of Death Comparison of Death	al Re	an; The I tificate h tor, page			rctim 26 Pi	ace of Death (Check only	performed? de 1 Yes 2 No 1	eath?					
28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	Vita	hysicia this cert	၉	1 ☐ Yes 2 ☑ No Hospital:	tient 2 ER/Outpatient 3 DOA	er.		(Specify)					
O TO THE LEGISLATION OF THE PERIOD OF THE PE	on of	ending Path.	ficate:	1 ▼Natural 5 □ Pending (Month, Day 2 □ Accident Investigation	ay, Year) injury work	?	Describe how injury occurred						
27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide 4 Homicide 5 Pending 2 Noturn 3 Suicide 4 Homicide 4 Homicide 5 Pending 2 Noturn 3 Suicide 4 Homicide 5 Pending 2 Noturn 3 Suicide 4 Homicide 5 Pending 2 Noturn 3 Suicide 4 Homicide 6 Could not be determined 7 Noturn 8 Noturn 8 Noturn 9 N	Divisi	ital or Atta	al Certif	4 Homicide determined 28e. Place of Inju	ury - At home, farm, street, factory, office c. (Specify)			or Rural Route Number,					
The standard of the cause (s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as tated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as tated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		he Hospi in 24 hou he Funer	time, date and place, and due to	to the cause(s) and manner stated.									
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1192012		Voith Court		29b. Signature and title of certifier Wylyth A Corbin	330		29d. Date signed (Month, Day, Year)					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					death (Item 23a) (Type, Print)		- 1, 1/40						
Angela Corbin 2101 E. Jefferson St. Rockville, Md. 20785 State Registrar Angela Corbin 2101 E. Jefferson St. Rockville, Md. 20785			е	31. Date filed (Month, Day, Year) AN 2 4 2012 32 Registra	ar's Signatur	e, ma. 20/8	.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month BOWER GEE TOM $20\overset{\text{\tiny lear}}{12}$ РМ 8:45 January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3216 Guilford Avenue N/ABaltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Aug 20, Year 1930 1 □ M 2 🗓 F Months Hours Director 216-56-5437 Florida 81 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No N/A Maryland Baltimore City 10e. Street and Number ò 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be Funeral 3216 Guilford Avenue 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Chinese Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Residence other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F. 2 permit. Page 1 and 2 should be Department of Health and Ments. Important: If item 27 is marked any injury over В Hom Ngin Lucie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Gum Sheung Tom (Husband) 3216 Guilford Avenue, Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State Lorraine Park Cemetery 1/26/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Hi Furgal Service icensor MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1s Chamic nd mi disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-t Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown 9 Unknow s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform Hospital or Attending Physician: The Yes 1 Tyes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Carchier Resider Hospital: Other: 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 I Other (Specify) 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending nours after death.

neral Director; Aff
filled in by the fur 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral E Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 23a) (Type, Print) 6701 N.

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jamuaury 21,2012 10.748 P Physician/ Lois Margaret Tice Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Keswick Multicare Center Båltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Months Hours Min September 12,1914 Mary Tarid **Director** 214-01-6043 97 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location Director 10d. Inside City Limits 1XQ Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1344 W. 41st Street 21211 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 💢 No If Yes. Give 1 ☐ Yes 2 XXNo Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own HOme **Homemaker** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert B. Litchfield Annabelle Forthman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Thompson/Daughter <u>317 W.41st street, Baltimore, MAryland 21211</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or DRuid Ridge Cemetery January 24,2012 Pikesville, Maryland 21. Signature of Funeral Service Licensee Menss Scitz Funeral Home, Inc. 22. Name and Address of Facility Bringee lenss Scitz 3631 Falls Road, Baltimore, Maryland 21211 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each like. Approximate nterval Between Immediate Cause (Final set and Death Physician/ disease or condition resulting in death) Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine burial-transi that initiated events resulting in death) Last Due to (or as a consequence of). attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death detached Unknown 9 Unknown P.O. I signed by t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsv performe death? this certificate Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) in by the funeral 27. Manner of Death Certificate: 28b. Time of within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Year Scott Andrew Tyner 2012 0600 A M 2 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death FRANKLIN SQUARE HOSPITal Baltimore KOSedal- Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV • 4 , 1950 5. Social Security Number 218-58-4421 **Funeral** 1**X** M 2□ F Months Days Hours Min 61 M D Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Baltimore Essex 1 ☐Yes 2X No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21221 USA 2328 Poplar Road Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items; any injury or other traumatic event, Its Medical Examiner muonee. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 TNo Specify: 2 White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BridgestoneAmerican Elementary/Secondary (0-12) College (1-4or 5+) Tires Service Manager 4yr 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) Della Heaton Andrew Tyner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2328 Poplar Road Baltimore MD 21221 Sallie A. Tyner /wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Belair Memorial 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/27/12 Belair MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature / Dineral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Party. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** multiforme GliobLastoma IYR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner recurrent e1Zuie Month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence on ATrial fibrillation w Days resulting in death) Last Due to (or as a consequence of): Physician/Medical EmboLism Pulmonar. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Ye ar 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an perform 2 No 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural

law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, Hospital or Attending Physician: The death.

the Marylan

filed within 72 hours after death

Baltimore, Maryland 21215-0036

C

THE LA POLITION AT

sician and burial-transit attending physician for use as the buria page 2 should peen certificate Medical Certification: To After t

2 Accident

4 Homicide

(Check only one)

3 Suicide

ithin 24 hours after death.

the Funeral Director: A propletely filled in by the fu within 2.

State Registrar

this

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29b. Signature and title of certifier 29c. License number 0-54736

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

FRANKLIN Square DR Balto md 21237 AL Lun 9000 Kyeuna

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

JAN 2 4 2012 31. Date filed (Month, 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 21, 2012 ear 10:35A Gaetano Thomas Terminella **Medical** 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake BelAir Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days Hours 213-28-4869 90 **Director** 1 XM 2 □ F March 16,1921 Sicily Usual Residence of Decedent show 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2X No Md. Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 1326 Hidden Stream Drive 21009 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Completed 3 XWidowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12th Book Binder Optic Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luigi Terminella Concetta Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 1326 Hidden Stream Drive. Abingdon, Md. 21009 Venera A. Amati 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer 1-26-2012 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tune of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home of BelAir 610 W. MacPhail Road BelAir, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death ASPIRATION PHEUMONIA Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner da Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown signed by t Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2/X No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes No Hospital Other: 은 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cuttlying Name Fractitioner 1, the last of my knowledge, and manner stated at the lime cate and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Medical dock D71076 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 520 Upper Chesq peaker Dr. AMBELINA ESTOSILLA 32. Registrar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** IFRYLN TURNER JANU 17 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Johns Hopkins Bayview Medical Center **Baltimore** If Under 24 Hrs. B. Date of Birth (Month, Day, Year)
April 4,1941 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days Maryland 70 Director 217-38-5776 Usual Residence of Decedent f show 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Dunda1k 1 ☐ Yes 2 X No Director MD Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2001 Dineen Drive United States Funeral 21222 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. U Yes 2↓ No Yes, Give within 72 hours after 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: þ Specify: 3 Widowed 4 Divorced White Year or Dates: "natural", Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Sales 12 Years Clerk Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kathryn L. Hissey William R. Fischer ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health a:
Important: If item 27 is
any injury or other trau Mr. Theodore J. Turner (Husband) 21222 2001 Dineen Drive Dundalk, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Faith Cemetery 1/21/2012 Baltimore, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. tregor 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** KESPIRATORY disease or condition resulting in death) FAILURE /Medical Due to (or as a consequence of): Examiner NEO MONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Duc to (or as a consequence of, Exami law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the at ald be detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 2 should be 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: has 2 **N**o 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🖪 No 1 Impatient Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA ည al or Attending Physical after death.
I Director: After this in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Tyes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) イフ RES-000 TANUARY 17 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAUREN GRAHAM 4940 Eastern Avenue, Baltimore, MD, 21224 MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

backe

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Physician/ 2012 January $a^{\,\scriptscriptstyle{M}}$ Ralph William Townsend 5:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Columbia Howard Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Director 011-24-7858 1**X** M 2 ☐ F 82 12/16/1929 MA Usual Residence of Decede 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director must be notified MD Clarksville Howard 1 🗆 Yes 2 🎦 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6703 Whitegate Road 21029 United States items death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1XX Yes 2 No1949-If Yes, Give Year or Dates. or, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: White Specify: "natural" 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Engineer/Business Owner Computer Science Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Ralph William Townsend Alice Reeves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mark William Townsend - Son 11881 New Country Lane Columbia, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/27/2012 | Marriottsville, MD Crest Lawn Mem. Gar. 21. Sign vi re : f Funenal Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pholidian/ STIPE disease or condition Medical resulting in death) Due to (or) s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter charming Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Month Year Pregnant at time of death filled in by the funeral director, page 2 should be detac. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed? Yes 2 No 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗆 Yes 🔎 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending Accident 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

tila

JAN 2 4 2012

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ January 21, 201^e2 Khon Thai 4:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours (Month, Day, Year) **Director** 586-30-8788 75 Yrs January 8, 1937 Vietnam Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13204 Cabinwood Drive 20904 United States death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner ō 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give þ Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Asian Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Computer Analyst NASA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Qui Tran Anh Thai and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Thai / Son 3198 Lorenzo Lane, Woodbine, Maryland 21797 item Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date Montgomery or other place) Crematorium, Inc. January 2012 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland 4 Donation 5 Other (Specify) Robert A. Pumphrey Funeral Home, Robert A. Pumphrey Runeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician. Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Examine if any, leading to immediate Due to (or as a consequence of) executed Cause (Disease or injury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 phys the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown signed by 1 d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? or Attending Physician: The law page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 X No ၉ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending nours after death.

neral Director: Aft
filled in by the fur 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely f Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year, 3.40c SW D35112 January 21, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 Paul B. Baker, M.D.

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 4 2012

32. Registrar's Signature

Veale, Rita Harland DIS

	State of Maryland / Department of Health and Mental Hygiene 1-State Registrar Certificate of Death Reg No. 2 0 1 2 0 11, 9 7															
			State Registrar			Cer	tificate of	Death		F	Reg. No. 2	0.12	01197			
	Dhusisia		1. Decedent's Name (First, Middle	e, Last)						Date of Dea Month		Voor	3. Time of Death			
	Physicia Medic		Rita Boyd Veal	e						an.	21, 20	12 ^{fear}	12:15 P ^M			
	Examin	er	4a. Facility Name (if not institution	, give street and num	nber)		4b. City, Town, o	or Location of	f Death		4c. Coun					
			Shady Grove Ad 5. Social Security Number	ventist H		and to lade along a	Rockv		24 Hrs. I a	D-1(D) II	Montgomery # Birth G Birthplace (State or Fo					
	Funeral Director		577–38–1488	1 □ M 2 X F	7. Age (In yrs. Ia 84		Months Days	Hours	Min.		nth, Day, Year) Country)					
	وقالت		Usual Residence of Decedent	1 - W 2201		Yrs.			Ma	ay 12,	1927	Washi	ington, DC			
	land short	ţo	10a. State 10b. County			y, Town or Loc						10	0d. Inside City Limits			
	Mary 28a-i otifie	Director	MD Montgo	mery	Ro	ckville							1 🔀 Yes 2 🗌 No			
	th the	al D	10e. Street and Number				10f. Zip Code				10g. Citizen o		try?			
	ms 2:	Funeral	629 West Lynfi			140.4	208		-i=2 /Cif-	Van an Na	USA					
	or ite	y F	11. Marital Status 1 ☐ Never Married 2 😾 Mar	Armed Fo	edent Ever in U.S rces? 2 🔀 No		Vas Decedent of F Yes, specify Cub					ice - America ack, White, e				
21215-0036	s afte ral", Exan	Completed by	3 Widowed 4 Divorced	1	Yes 2 No	Specify:			Specia	y: Cauc	asian					
2-0	hour hatu dical	olete		nt's Education est grade completed	1		ent's Usual Occu ind of work done	ofworking	16b. K		Business/Ind	lustry				
2	nin 72 ne. han '	om	Elementary/Secondary (0-12)	College (1)	or working		Glassia al	le							
2	Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)															
anc	The purpose of the pu															
During State of State												or Town, State, Zio Codel				
Ĕ	12 sh alth ar 27 is r trau		Ralph C. Veale/							ville, MD 20850						
re,	1 and of Hea item		20a. Method of Disposition			lace of Dispos	sition (Name of natory or other pla		Date		20c. Location					
m	Page nent or nent or ant: If ant: If ant: If ant: If ant: If or ant: If ant: I		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (5	3 ∐ Removal from Specify)			ney Crei		1/25	/12	Woodbi	ne, MD)			
Baltimore,	permit. Departr Imports any inju		21. Signatus Funeral Service I	icensee / / / /	/						ce P O	Box	784			
ш	<u>205</u> 29	- 1	twent of	Henry	M0125							sville	784 e, MD 21029			
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that only one cause on ea	caused the death ach line.	h. Do not ente	r the mode of dyi	ng, such as c	cardiac or res	spiratory arre	est,		Approximate Interval Between			
462	Medical	7	Immediate Cause (Final disease or condition resulting in death)		ocard	lial	Info	rcti	ion			- 27	Onset and Death			
-	Examiner		resulting in death)	Due to	or as a consequ	ience of):										
		Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a consequ	ience of):										
+ Is cause Fuer Underwork																
	execu an and rial-tr	EX	that initiated events resulting in death) Last	Due to	(or as a consequ	ience of):				-						
09	death certificate be executed ne attending physician and ed for use as the burial-transit	dicał		d												
387	rtifica ing pl	/Me	IF FEMALE:	00. 1/												
×	of the center of	ian,	23b. Was decedent pregnant in the past 12 months? 1 — Yes 2 No	1 🗆 Live	tcome of pregnal Birth 2 Feta nant at time of d	I death 3	Ectopic pregnan	су				ate of delive	ery Day Year			
m.	the a	Physician/Me	1 Yes 2 No	9 🗀 Unk		ieath 5 L	Other (specify) _						J-,			
P.O. Box 687	requires that the death certifical been signed by the attending p should be detached for use as	by Pr	Part II. Other significant condition	ons contributing to c	leath but not resi	ulting in the u	nderlying cause g	iven in Part I.		23e. Did to	bacco use cor	ntribute to the	e cause of death?			
S,	uires n sigr uld be	q pa								1 🗆 Y	es 2 🗆 No	3 🗌 Prob	oably 4. Unknown			
Ö	w req s bee 2 sho	Completed								24a. Was a		. Were autop	osy findings available inpletion of cause of			
e S	Physician: The law this certificate has ral director, page 2	νος								autop: perfor 1 Yes		death?	·			
e	ian:] ertifica ctor,	Be	25. Was case referred to medical examiner?				26. F	lace of Death	h (Check onl			erence conc				
>	hysic this ce al dire	은	1 Yes 2 No		Inpatient 2			4 ∐ Nur	rsing Home	5 🗌 Reside	ence 6 🗆 Ot	her (Specify)				
סר	ding Ph h. After th funeral	Certificate:	27. Manner of Death 1 Natural 5 Pendir	28a. Date (Mon	of injury th, Day, Year)	28b. Time of injury	28c. Inju wor	k?		Describe ho	ow injury occu	rred				
Sior	death death stor: /	tific	2 Accident Investi	not be	of Injury - At ho	form stro		Yes 2 1	_	Leastine (Ct	two at a m -! African	har ar Dural	Route Number,			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Cer	4 Homicide determ		ng, etc. (Specify)		et, lactory, office		201.	City or Town		ber or nurar	noute Number,			
	ospita hours ineral ly fille	ledical		Physician: To the b												
	To the Hos within 24 ha To the Fun completely	Med		xaminer: On the bas Nurse Practitioner									use(s) and manner stated. tated.			
	North North		29b. Signature and title of certifier				29c. Licens				29d. Date sign					
			Amet le	L' mo				0640			Janu		21,2017			
ا	121		30. Name and address of person		se of death (Item	23a) (Type, P	rint) Lical C	4 1	_ 10	. ما م دد	110	MD	20850			
	Stat	e	31. Date filed (Menth Dayren	ria MD 32. A	egista 's Signa	No Red	Creat C	Tr y	7 10	- UC	offic_	IVLU	2030			
	Registra		JAN 2 4 2012	Change !	P. 19											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 30 per dyr g923 1-24-12 vt
State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 23 2012 Modesto Miranda Villafane 7:05a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Harford <u> Harford Memorial Hospital</u> Havre de Grace Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 26, Year) 923 1 🛣 M 2 🗆 F Months Days Hours Min Puerto Rico Director 88 582-16-5722 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f XX Yes 2 No Harford Aberdeen Maryland 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 21001 743 Walker Street USA items and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 2 No 1946-Black, White, etc. "natural", or 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 1XXVes 2□No Specify: Puerto Rican If Yes. Give 1948 Specify: HISPONC 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer Engineering 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Villafane Cecilio Miranda Galarza Francisca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Snowgoose Court, Havre de Grace, MD 21078 Modesto L. Miranda (son) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel 1/25/2012 Forest Hill, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death TACHY CAPDIA Physician/ VENTRICULAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a presentation of Exami certificate be executed the bunial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No detached the 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown hodiusto Miranda 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performe 1 🗌 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 🖊 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28a. 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No ✓ Natural 5 Pending injury Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Name Prantioner: To the boat of my knowledge death occurred at the time. Sate and place, and one to the cause(c) and manner as stated. 29a. Certifier (Check the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 9110 23-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khalid Puthawala 602 S. Atwood Rd. #206 Bel Air, Md. 21078 31. Date filed (Month, Day, Year) -State

DHMH 17 Rev 7/2009

Registrar

IAN 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For Stete Registrar	State of N	Maryland		rtmen tificate			and M		Reg. No.	2012	0	1499		
	Physicia	an	1. Decedent's Name (First, Middl			2. Date of De Month January	ath Day 20	Year 2012	3. Time	of Death A M							
S	/Medic Examin	al	4a. Facility Name (If not institution 715 Maiden Choice	hts	4b. City,		Location of	of Death	ranuar y	4c. County of Death Baltimore			A				
	Funeral Director		5. Social Security Number 358-03-5170	6. Sex 1 ☐ M X X F 7.	Age (In yrs. lasi 98	t birthday) Yrs.	If Under Months	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 05/25/1913							9. Birthplace (State or Foreign Country) Kentucky		
	sryland show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Catonsville											10d. Inside	City Limits		
	n the Marrants or 28a-f	Funeral Director	MD Ba	numore			10f. Zip			iie		10g. Citize	n of What Cou	ntry?			
	ath wit	raiD	715 Maiden Choice		et Cours in 11 C	142.1	Man Dagad		21228	gin? (Sp	acify Vas or No	. 14	USA Race - Ameri	can Indian			
936	urs after de el', or items	by Fune	11. Marital Status 1 Never Married 2 Mar Wildowed 4 Divorced	If Yes, Give	is? ∐No		f Yes, spec		Specify:		ecify Yes or No Rican, etc.)		Black, White,	etc.			
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygione Hysione Hygione Hy	Completed by	15. Deceder (Specify only highe Elementary/Secondary (0-12) 12	t's Education st grade completed) College (1-40		(Give	lent's Usua kind of wor DO NOT us Off	rk done d se retired,	lurina mos	t of work	ing	16b. Kind	of Business/In	,			
d 21	filed w Hygie other t	Be Co	17. Father's Name (First, Middle,					100 141		er's Name	e (First, Middle	, Maiden Sumame)					
ylan	should be nd Mental marked o	ToB		Wm Aaron Rol				(2)			Mary B						
Mar	id 2 shu Ith and 27 is m r traum		19a. Informant's Name/Relationship (Type, Print) James Lawrence Murdoch / Son 19b. Mailing Address (Street and Number or Rural Route Number) 6557 Beechwood Drive, Columbia, MI										iown, State, Zij	CO08)			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or Items 23a or 28a-f show importent: If item 27 is marked other than "naturel; or Items 23a or 28a-f show injury or other traumatic event, Item Medical Examines must be notified at once.	20a. Method of Disposition 1 Burial 2 Coremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory 1/23/2012										Beltsville, MD					
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Liceosee 22. Name and Address of Facility Dorota Marshall Lewel Charles Maryland Cremation Services, PO BOX 1413 Baltimore, MI														
	Pnysician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition		Approxim Interval B Onset and	etween											
	/Medical Examiner		resulting in death)	Due to (or	as a consequer	nce of):											
-	ted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Errer Undersying Cause (Disease or injury that initiated events	<	as a consequer	nce of):											
,092	te be executed ysician and ne burial-transit	icai Exa	resulting in death) Last	C. Due to (or	as a consequer	nce of):											
. Box 68	n certifica anding ph use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopers? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal de at time of deat	ath 3	Ectopic pro					23	d. Date of deliv Month	ery Day	Year		
ds, P.O	requires that the death een signed by the atte hould be detached for	þ	Part II. Other significant condition Atrial Fibr	ons contributing to death	n but not resultir	ng in the ur	nderlying ca	ause give	on in Part I		23e. Did t	_	contribute to t		f death?]Unknown		
Vital Records,	The law te has b	Completed	Moly myslera	Neumo	Rea	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No							24b. Were auto prior to co death? 1 ☐ Yes	ppsy finding impletion of 2 \(\text{No} \)	s available cause of		
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		1/0	t 3 🗆 DO	Othe			Check only		Other (Special	641			
	gr en	on: To	1 Yes 2 No 27. Manner Death 1 Natural 5 Pendii	1 ☐ Inpa 28a. Date of I (Month,		2	28d. Describe			y /							
Division of	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Attencembletely filled in by the fune	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At home etc. (Specify)	e, farm, str	M eet, factory		/es 2□		28f. Location (City or To		Number or Run	al Route Nu	mber,		
_	Hospitel 24 hours a Funeral tely filled	edical Co	29a. Certifier Certifyii (Check only one)	ng Physician: To the be Examiner: On the basis and manner	s of examination	edge, death	occurred a	at the tim in my op	e, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	nd manner as s lace, and due t	tated. o the cause	(s)		
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/20/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael K. Ro Mo III Maida Choice W. Catansville Mp 212 State Registrar 31. Date Wed (Month, Day, Year)																
)			30. Name and address of person	who completed cause of	of death (Item 23	Ba) (Type,	Print)	C	0100	(1)	Cata	151114	e NID	21	22		
,	Sta Registi		31. Date God Mogh, 42012	Seneva 32. Regi	strart Signatu	ale	,				CZ407		_ / -(//	(

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2:30 MARY PATRICIA WICH PM Janaury Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Mercy Ridge Timonium Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours 215-30-9869 1**XX**M 2 □ F Director 10/07/1932 Maryland f show 10d. Inside City Limits Department of Health and Mental Hygiene. Important's or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be notified at any injury or other</u> traumatic event, the <u>Medical Examiner must be notified at once.</u> 10b. County 10c. City, Town or Location Director Maryland Baltimore Timonium 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Pot Spring Road 21093 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Specify. 3X Widowed 4 Divorced Completed White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Kathleen Shields Thomas Gardiner Hope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Gardiner Dorney 309 Main Street Gaithersburg, Maryland 20878 Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XX Cremation 3 Removal from State GreenMount Crematory 01/24, 2012 Baltimore, Maryland Donation 5 Other (Specify) permit. ignature of Funeral 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARREST Cardiac MIN. JES Viedical resulting in death) Due to (or as a consequence of) xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant a 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Schallation Hypiotension Chronic Hopatity 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ANEMIA OF CITAONIL autopsy performed? Yes 2 (19)No this certificate has ral director, page 2 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🔲 Yes 2 🔲 No Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

1447

32. Registrar's Signature

York Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Green

31. Date filed (Month, Day, Year,

JAN 2 4 2012

M. D.

262966

Ste 100 Towson MD

January

21093